EXHIBIT 6

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
AT CHARLESTON

IN RE: ETHICON, INC. PELVIC REPAIR SYSTEM PRODUCTS LIABILITY LITIGATION	MASTER FILE No. 2:12-MD-02327
This document relates to Wave 11 Cases	MDL 2327 JOSEPH R. GOODWIN US DISTRICT JUDGE

August 7, 2019

Deposition of LAWRENCE LIND, M.D., held at 30 Cutter Mill Road, Great Neck, New York, commencing at 12:57 p.m., on the above date, before Marie Foley, a Registered Merit Reporter, Certified Realtime Reporter and Notary Public.

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REQUEST FOR PRODUCTION OF DOCUMENTS

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- - -
12:57 p.m.
Great Neck, New York
- - -

LAWRENCE LIND, M.D., the Witness herein, having been first duly sworn by a Notary Public in and of the State of New York, was examined and testified as follows:

EXAMINATION BY
MR. DeGREEFF:

Q. Good morning, doctor.
Can you tell us your name?
A. Lawrence Lind, L-I-N-D.
Q. And Dr. Lind, you have been hired as a general liability expert for Ethicon in this litigation.
True?
A. Yes.
Q. Have you also served as a case-specific expert for Ethicon in various cases in this litigation?
A. I have.
Q. How many?

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A. About four to -- four to six cases.
Q. Have you ever been hired as an expert witness for any other transvaginal mesh manufacturer?
A. No.
Q. And understanding I'm not asking you about consulting. I'm just asking you about litigation expert.
A. No, I have not.
Q. Do you have an understanding of what you were hired to do on behalf of Ethicon in this litigation?
A. Yes.
Q. What is that?
A. To give opinions regarding efficacy and safety of mesh and sling products.
Q. Any particular mesh and sling products, or just mesh and sling products generally?
A. So by that you mean did I dedicate a deposition on the TVT where we're talking about the sling family, TVT-O, TVT-Abbrevo and TVT-Exact.

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Q. Doctor, you've been deposed before today?
A. I had a deposition on the TVT, and in medical malpractice cases I've been deposed.
Q. Other than the general deposition you gave on the TVT in 2017.
Is that right?
A. '17 or '18.
MS. GERSTEL: It was '17, yes.
BY MR. DeGREEFF:
Q. Other than that deposition, have you been deposed on any Ethicon mesh product?
A. Prolift.
Q. And that was also the general deposition you gave in 2017?
A. Yes.
Q. Have you given any case-specific expert depositions on behalf of Ethicon in this litigation?
THE WITNESS: In Tays, right?
Did we do a deposition in Tays?

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MS. GERSTEL: That was in New Jersey. The Carolyn Tays matter in New Jersey.
BY MR. DeGREEFF:
Q. So I think the answer is yes, you've been deposed before?
A. Yes, in one case.
MS. GERSTEL: Could I just state for the record that the 2017 deposition that Dr. Lind gave, it was on TVT and Gynemesh, actually. Not Prolift.
MR. DeGREEFF: Okay.
BY MR. DeGREEFF:
Q. Have you ever been deposed previously as an expert for any other transvaginal mesh manufacturer?
A. There was a communication between myself and I was working on research and development for a vaginal mini sling for Boston Scientific, and some of the feedback I gave in a research lab was of interest to the counsels. So I was deposed to answer questions regarding my

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feedback on -- at the research phase of a mini sling.
Q. And what was the mini sling product?
A. At the time, I don't recall. I don't know if it was named at the time. It was early in the research and development.
Q. So you were deposed in the Boston Scientific transvaginal mesh litigation?
A. Yes.
Q. What was the subject matter of that deposition?
A. It was my positive and negative feedback for improvements and design on the device at a research and design lab.
Q. The design of a Boston Scientific product.
Is that right?
A. Yes.
Q. What was your involvement in the design of that Boston Scientific product?
A. They -- the phase that they had

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prototypes for, they asked me to use the device on cadavers and comment on the handling, the ease of placing the sling, potential improvement, potential problems, things that could be improved.
Q. And you pointed out problems.
Is that right?
MS. GERSTEL: Objection.
A. I pointed out beneficial aspects and areas that I thought might be improved.
Q. What were the beneficial aspects of the Boston Scientific sling that you pointed out?
A. I thought the shape of the handle was favorable for being able to plant the anchor at a good angle to the obturator membrane. I thought they had some -- a line at the midline I thought was very helpful in helping to keep the sling 50 percent on each side.
And the remainder of the positive and negatives I don't recall. This was about five years ago.

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Q. Are those two positives you just pointed out, are those design aspects of any of the TVT slings?
MS. GERSTEL: Object to form.
A. You know, I don't use mini slings presently. So I haven't been looking at them and comparing them for quite a number of years. It's within the aspect of slings that I look at, I don't have comparisons.
Q. Well, the TVT mini slings -- the TVT-S, which is the Ethicon mini sling, is off the market.
Right?
A. Yes.
Q. So you wouldn't be using something that's off the market?
A. Correct.
Q. And my question was the mini slings you're talking about, for example the handles, are the handles on the TVT products similar?
MS. GERSTEL: Object to form.
A. I haven't seen them for several

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years. So I wouldn't have enough recall to compare them.
Q. Well, do you currently use TVT products, TVT sling products?
A. Yes.
Q. What about the aspect you were talking about with the midline --
MR. DeGREEFF: Strike that.
Q. So, this was a transobturator placement device.
Is that right?
A. Yeah. With the mini slings, it's the -- you're placing it to the transobturator membrane without perforating it completely. So it does go to the obturator membrane, but not through it.
Q. Is it a good or bad thing to go through the transobturator membrane?
MS. GERSTEL: Object to the form.
A. The key aspect in designing the mini slings as I do recall giving input, is that you've got to get the anchor set.

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So it's got to go through -- you know, there's an interior and a posterior aspect of the obturator membrane with the muscle between it. So you have to get through the internal membrane for the anchor to be seated nicely. Otherwise it will pull out.

Q. Right.

I think you told me you've given one general liability deposition on the TVT and Gynecare product on behalf of Ethicon and four to five case-specific depositions on behalf of Ethicon previously.

Is that correct?

A. Those are case reports.

MS. GERSTEL: Objection.

A. They have not gone to deposition.

MR. DeGREEFF: Strike that. My fault.

Fair point.

THE WITNESS: Okay.

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BY MR. DeGREEFF:

Q. So, how many depositions have you given total on behalf of TVM manufacturers in litigation brought by women against them claiming complications?

MS. GERSTEL: Object to the form.

A. So, there's the -- there's the Gynemesh and TVT, there's the one case-specific report, and there's today.

Q. Have you ever testified at trial for any manufacturer of transvaginal mesh?

A. No.

Q. Have you ever been an expert witness in cases unrelated to transvaginal mesh?

A. Yes.

Q. What kind of cases?

A. I take malpractice cases, both plaintiff and defendant cases, for various law firms in the area that know me and decide when the problem of interest is in my area.

Q. How many times have you been a

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expert in med-mal cases?

A. I would say two or three cases a year for the last ten years.

Q. So 20 to 30 total probably?

A. Yes.

Q. Of those 20 to 30, how many have been on behalf of the plaintiff, the injured party?

A. Two.

Q. And what kind of cases were those?

A. A woman was in labor and the baby was stuck, and the maneuvers used to, you know, panicked to get the baby out were excruciatingly outside of the usual protocols, and she endured tremendous pelvic floor injury.

And the second one was a laparoscopic case with a patient with five or six previous surgeries with a bowel injury. There was steps taken to verify safety of a laparoscopic case in a patient with a difficult abdomen.

Q. So, of the 20 to 30 med-mal

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cases you've been an expert in, only two of them you're the plaintiffs' expert?

A. Correct.

Q. Is it fair for me to assume you understand how this process works, the deposition process, so we don't have to go through the rules?

A. Absolutely.

Q. Okay.

A. I will be a good exchange partner in this process.

Q. Perfect.

Sir, have you ever been sued?

A. I had -- as a resident, I was named in three cases. And one of them settled. The settling had nothing to do with my role in the case. And the other two I got dropped.

And since that time, I have not been sued.

Q. What was the claim -- were the three cases like companion cases or something?

A. One was a very difficult case

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with a mother came in sepsis in labor with twins in labor, and it was clear that she was septic. The vaginal delivery went routinely, but the high risk maternal fetal medicine doctor was suspicious that she probably had group A strep and was in tremendous danger of serious complications, and both she and the baby died.

Q. What were the allegations against you in that case?

A. I don't -- they never questioned me for anything I did wrong. I think they wanted to know what my role was in surgery to see if I was more involved with something that might be tangible to the outcome. And I assisted with the delivery as a second hand. So my role was felt to be minimal.

The second one was a patient had a abnormal bleeding after a C-section, and I was called with the GYN oncology team to help do some artery ligation to reduce bleeding, and in the process of the

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procedure, the femoral nerve was compressed. So she had some lack of sensation in the -- you know, we saved her -- well, may have saved her life. We controlled the bleeding, but in the process of controlling the bleeding, we kinked and caused some pressure on one -- the nerves to the vessels of one of her legs. It was diagnosed in the recovery room and she had to go back and have that released, but she did fine, but she did have to go back.

Q. When you serve as an expert in a case, is it your goal to promote the truth?

A. Yes.

Q. And not to be an advocate or promoter for one side or the other?

A. Correct.

Q. You agree that an expert's opinion should be unbiased and objective?

A. I agree.

Q. When you gave your opinions in this litigation, you wanted to be as

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accurate as possible.

Is that fair?

A. Yes.

Q. And you want to be as thorough in your review of the available information, documents and literature as possible.

Correct?

A. Yes.

Q. And you wanted to make sure you got all of the information and considered all the information that was pertinent to your opinions, right?

MS. GERSTEL: Object to the form.

A. I would describe that -- the answer to your question is yes. However, as these interviews or depositions continue, areas of interest where the other party feels I have not been as thorough have come to attention. So I have continued my research and continued my reading and added to my knowledge and resources to be able to be more complete

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than I was even at the time of the report.

Q. So, you reviewed additional information after you had already issued your opinions?

A. Yes.

MS. GERSTEL: Objection.

BY MR. DeGREEFF:

Q. And did you change your opinions based on any of that additional information?

A. No.

Q. I take it what you actually did was just add some stuff to your reliance list.

Is that fair?

MS. GERSTEL: Object to form.

A. Well, things were added to the reliance list and some were just added to my general knowledge just to enable me to be more informed on issues that were brought to my attention that I had authority on, but not as much authority on as I would like to to be authoritative at a higher level.

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Q. So following depositions, you went and educated yourself better for the next deposition, is what you did?
MS. GERSTEL: Object to the form.
A. I had interest in being educated for the sake of being educated and knowledgeable for my practice and teaching, as well as for the depositions, yes.
Q. Did you want to make sure you had an understanding of both sides of the story before you gave your opinions?
A. Yes.
Q. The relevant information that you'd want to consider when rendering your opinions would include Ethicon internal documents.
Is that fair?
MS. GERSTEL: Object to the form.
A. That's a piece amongst a much larger group of documents, which is scientific literature. But those would be

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included, yes.
Q. Sure.
And it would also include medical literature?
A. Sure.
Q. Would also include standards and testing performed on the products?
A. Yes.
Q. Would it include making sure you understand the differences between the products?
A. Yes.
Q. Do you agree that opinions should be able to be substantiated by the totality of the most relevant available data and information?
MS. GERSTEL: Object to the form.
A. Yes.
Q. As a physician, your patient's safety is the most important thing.
Fair?
A. Yes.
Q. And would it be unfair for a

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physician to promote a position that jeopardizes the health or safety of his patients?
A. I'm sorry. Could you repeat that?
Q. Would it be unfair for a physician to promote a position that is adverse or could jeopardize the health or safety of his patients?
MS. GERSTEL: Object to the form.
A. If the information he was given was incorrect, that would not be appropriate.
Q. I think we're saying the same thing, but I'm not sure. Let me ask --
A. I'm not sure either.
Q. Let me ask my question again.
A physician shouldn't --
MR. DeGREEFF: Let me ask it maybe in a easier way.
Q. A physician should not promote a position that is adverse to the health, safety and welfare of their patients.

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Is that fair?
MS. GERSTEL: Object to the form.
A. I can agree with that.
MR. DeGREEFF: Let's do some housekeeping and mark some of this stuff you brought with you here.
(Lind Exhibit 1, Notice to Take Deposition of Lawrence Lind, MD, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. Dr. Lind, I'm going to hand you what I marked as Deposition Exhibit 1. That is the notice for your deposition today.
Have you seen that before?
A. Yes.
Q. When did you first see it?
A. A few weeks ago, a month ago.
Q. Who provided it to you?
A. Diana.
Q. That would be counsel for Ethicon that's here with you today?

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A. Counsel for Ethicon.
Q. And did you bring -- in fairness to you, so, you've brought some things with you today.
Correct?
A. Yes.
MR. DeGREEFF: One of the things is a flash drive, and I'm going to mark it as deposition Exhibit 2.
(Lind Exhibit 2, flash drive, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. Can you tell me what is on this flash drive?
A. That is a reliance list.
Q. So this would be all of the materials that are identified on the reliance list?
A. Those are all the materials on the existing reliance list. There are materials that I reviewed since that was created that are in my head that are also part of my knowledge and information I

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would share today that are not on the reliance list.
Q. Okay. We're going to get to that in a minute. I just want to make sure I understand what's on the flash drive.
The flash drive includes everything that's on the written supplemental exhibit list.
Fair?
A. Yes.
Q. Then you brought a couple other things with you that appear to be invoices.
Is that correct?
A. Yes.
(Lind Exhibit 3, invoice of Dr. Lind dated August 29, 2017, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. Can you tell me what Exhibit 3 is, doctor?
A. This is an invoice for review of relevant literature and summary of opinion

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statements regarding the defense expert report on TVT and TVT-Exact.
Q. So is that one of your invoices with regard to preparation of your TVT products expert report?
A. Yes.
Q. The general report, correct?
A. This would be the report we're looking at today.
Q. Correct.
And this would be the bill for the report regarding the general liability opinions you're giving in the litigation as a whole.
Fair?
Not case-specific.
A. Yes.
(Lind Exhibit 4, invoice of Dr. Lind dated July 1, 2019, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. Then can you tell me what Exhibit 4 is, please, doctor?
A. This is a bill for a

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case-specific report. The case-specific report appears to be an error. This is additional records that were reviewed for this preparation.
Q. Okay. So, Exhibit 4 is an additional invoice for review of records related to your general report on the TVT products.
Fair?
A. Yes.
Q. So, it says case-specific, but that's an error.
A. Yes.
Q. It should be generic report?
A. Correct.
Q. Is there anything else that you brought with you today?
A. I have my general report as it was served to you.
Q. Okay.
A. I prepared just an index. It just helps me when you ask me about a certain topic, it lets me go to a spot in my report more quickly.

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I have a 2008 and a 2015 IFU.
And I have the articles that are referenced in my report.
And I have an index of those articles so I can go to them quickly when we want to discuss them.
Q. Is everything you have in front of you included on the flash drive?
A. I believe it is. And the flash drive probably has more articles than are here.
Q. Is the index included on the flash drive?
THE WITNESS: I don't know the answer to that.
MS. GERSTEL: It should be, but I can confirm that.
MR. DeGREEFF: It's okay. Let's just go ahead and mark it.
(Lind Exhibit 5, handwritten Report Index of Dr. Lind, was marked for identification, as of this date.)
MR. DeGREEFF: And I'll let you continue to use it, obviously.

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THE WITNESS: Do you want a copy so you have one to keep?
MR. DeGREEFF: No, that's okay.
BY MR. DeGREEFF:
Q. Doctor, I've marked Deposition Exhibit 5.
Can you tell me what that is?
A. It's a long report, you know, 50-plus pages, and we're here to have a several-hour discussion about what's in the report, amongst other things you may want to discuss. And it was -- I found from the past experience that hunting for areas that we're talking about is useful to just have a one-page thing that lets me go to the spot a little more quickly.
Q. Okay. So, this is essentially -- Exhibit 5 is essentially a skeleton outline of your report so that you can --
A. Right.
Q. -- find things more quickly?
A. Right.
Now, I will say, for complete

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disclosure, sometimes when we go to the report, we will go to an area of the report and the key thing's going to be to discuss what's in that section. So sometimes I have written maybe three words that reminds me of what the study is talking about in that section. My goal there is to get to that and I say let me go to the study, and we've got to go through the binders and find it and locate it and I want to review it. I can save us that time.
So there are a few words here and there that just remind me of what an article said.
Q. Okay. Fair enough.
So, sir, this is a pretty simple question.
You're being paid to serve as a expert witness for Ethicon in this litigation.
True?
A. Yes.
Q. And, so, other than Exhibit 3

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and Exhibit 4, have you sent any bills for your work on the TVT product general expert report?
A. Let me just -- may I just see those one more time?
Q. (Handing.)
A. (Perusing document.)
I have not.
Q. Have you incurred any more time to date that you have not billed for yet?
A. Yes.
Q. About how much time is that?
A. About 25 hours.
Q. Will you be billing that 25 hours at $500 an hour?
A. I will.
Q. And is $500 an hour your rate?
A. Yes.
Q. What is your rate for the deposition here today?
A. Seven thousand five hundred.
Q. So it's 7,500 is your rate for a full-day deposition.
Is that correct?

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A. Yes, it is.
Q. Okay. So, check my math, but that's about another $20,000?
A. About right.
Q. So that would be initially to the 10,500 and 16,000 that are set forth in Exhibits 4 and 3?
A. Yes.
Q. So that's, what? $46,500, roughly, that you've billed -- that you will have billed to date once those invoices go out for your work on the TVT general expert report?
A. Yes.
Q. How much did you --
MR. DeGREEFF: Strike that.
Q. Did you do any additional report related to the Gynecare mesh products?
By that I mean I guess the POP products.
A. We have a Gynemesh general report.
Q. And was that also done in this litigation for Ethicon?

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A. Yes.
Q. And those were general expert opinions?
A. Yes.
Q. What did you -- how much have you billed to date for your work on that?
A. I don't recall specifically. It was two years ago. It would be in the same ballpark. Maybe just slightly less because it was four products, and I think it was a little bit less, but it was in the same ballpark.
Q. So 40 to $50,000? Somewhere in there?
A. I would say 30 to 50 is the range I could support.
Q. Who would know the exact answer to that question?
A. I could go back to my bank records. And am certain that whether it's the counsel's office or accounting or Gynecare's accounting, I'm sure they would have it as well. I know I would have it if I reviewed my bank records.

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Q. When were you first approached to serve as an expert for Ethicon in the transvaginal mesh litigation?
A. About three-and-a-half years ago.
Q. My math's not very good, but would that be the beginning of 2016?
A. Somewhere in the 2016.
Q. And you've also done multiple case-specific expert reports on behalf of Ethicon litigation.
Right?
A. Yes.
Q. Approximately how much have you billed them for preparing those reports?
A. If you put all these together, you put everything together, I think we're probably in the 200 to $250,000 range. If you put everything you've already, you know, kind of itemized and now tried to expand to the case-specific, say from when I started my relationship with them til now for invoices related to pelvic mesh expert review and participation, it's 200

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to 250,000.
Q. And that is since the beginning of 2016?
A. Yes.
Q. I just want to make sure I understand what you're saying. I think I do.
So, since you were first contacted by Ethicon to serve as an expert in this litigation in early 2016, you've been paid roughly 200 to $250,000 for your work as an expert witness?
A. Yes.
Q. And that would not include any consulting work you've done for them. It would just be in relation to being a litigation expert?
A. This is everything from 2016 and current. Consulting work that I did for Ethicon is more than a decade ago. So this is excluding what was done in the 2000 to 2010 was different type of work where I was working with them on product development and all the slings that we

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discussed.
Q. Well, the last time you worked for Ethicon wasn't in 2010.
Right?
A. I don't recall exactly when. It was probably earlier than that.
Q. Well, it was actually later than that.
Right?
MS. GERSTEL: Object to the form.
A. As a consultant?
I don't recall precisely.
Q. As you sit here right now, do you have any understanding of how much you were paid by Ethicon when working for them under a consulting agreement, master consulting agreement, any other such verbiage they used? Did you have any idea how much they paid you?
A. You know, I don't have an accounting on it on hand.
I would estimate in the 20 to 35,000 range.

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Q. Well, in 2011 alone it was over a hundred thousand.
Right?
MS. GERSTEL: Objection.
A. I would have to review that.
Q. Okay. We'll get to that.
Do you keep any kind of itemization of your time spent on --
MR. DeGREEFF: Strike that.
Q. So, your invoices are broken down, you know, fairly broadly on Exhibit 3 and 4.
Do you have any -- do you submit any kind of a more detailed itemization to Ethicon?
A. I don't.
Q. Do you have a more detailed itemization?
A. The documents that go into making one of those invoices are marked individually. I'll get a binder and I'll go through it and I'll just mark on the front how many hours, and then I take those handwritten totals and make a common

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invoice.
Q. Okay. So, is there -- I mean, when you write out your handwritten, do you write out what you did?
A. Yeah. I write review of binder. You know, TVT literature, review of literature search on my own, TVT complications. Whatever the category is that I've taken as a meaningful piece of work, I package it and make that a, you know, a time element package that's useful to put a signature on. Or it might be where I have everything I have to look at and I'll go through everything that I have and I'll mark what I've looked at.
Q. When you're keeping those notes, do you write down, for example, like if you have a call with defense counsel?
A. If I have a what?
Q. A call with defense counsel.
A. There are some -- there are some invoices that have phone meeting or in-person meeting with counsel.
Q. Where are those invoices?

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A. I think those are on some of the case-specific and I think on the -- they may be on the invoice for the Gynemesh. I think it includes one preparatory session that was listed, as I recall. I'm not certain of that.
MR. DeGREEFF: Have we -- have those been produced?
MS. GERSTEL: At his Gynemesh deposition, we produced invoices. I can't tell you specifically what they were, but I know that we did produce invoices at his Gynemesh deposition.
MR. DeGREEFF: Okay. What about the case-specific?
MS. GERSTEL: The one case-specific deposition that he's had, it was the Tays deposition in the New Jersey litigation, and we did produce invoices related to his work in the Tays matter at that deposition.
MR. DeGREEFF: Okay. Yeah, that's our case.

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BY MR. DeGREEFF:
Q. How many hours would you say -- we'll get to this, but how many hours would you say since you started working with Ethicon in 2016 that you've spent working as an expert witness for them?
MS. GERSTEL: Objection.
A. Two hundred thousand divided by 500. Whatever it is.
I'm also not great at quick math.
200 to 250,000 divided by 500. So 500 times -- 500.
Q. Five hundred hours or so?
A. Yeah.
Q. I guess 400 to 500?
A. Yeah. Yes.
Q. And in this litigation --
MR. DeGREEFF: Strike that.
Q. In preparation of the report we're here about today, which is the TVT general report, based on your Exhibit 3 and Exhibit 4, it looks like you spent about 53 hours, plus the 25 that you've

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spent since then.
Is that right?
A. What's on those two plus 25.
Q. So double check me, but that's, what? 78?
A. 21 and 32 is 53 and 25.
Yeah, about 78.
Q. How much of that 78 hours was spent --
MR. DeGREEFF: Strike that.
Q. How much of that 78 hours was spent in actual drafting and preparation of the report itself?
A. One-third.
Q. 25 to 30 hours?
A. Yes.
Q. And the rest of it was spent doing what?
A. Research and reading.
Q. Did you prepare the reliance list?
A. The reliance list has articles provided by counsel, as well as several -- many, many that I found on my own Pub Med

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searches that I felt were relevant.
Q. Who drafted the reliance list?
A. Counsel.
Q. That's counsel for Ethicon?
A. Yes.
Q. I guess when I ask that question, to be clear, who drafted the supplemental reliance list?
A. I would come up with more articles and would say they're relevant, and then they would be added by counsel for Ethicon.
Q. So counsel for Ethicon drafted the supplemental reliance list?
A. Yes.
Q. So, the other it's like 45, 50 hours --
MR. DeGREEFF: Strike that.
Q. The other 50 hours or so were spent in review of the materials on the reliance list?
A. Finding the materials and reviewing them, yes.
Q. Does that 50 hours include any

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time preparing for your deposition with counsel?
A. Yes. We met twice.
Q. About how long did you meet each time?
A. Four hours.
Q. So that's about eight hours total?
A. Yes.
Q. And when were those meetings?
A. Last week and the week before.
Q. Where were they?
A. They both -- one was here. One was in my office.
Q. That eight hours was included in the 78 we discussed earlier.
Right?
A. Yes.
Q. So, more like 40 hours probably locating and reviewing the materials in the reliance list?
A. Sounds about right.
Q. Any phone calls with counsel included in that 78 hours?

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A. One or two brief, minutes, minutes on each.
Q. During your meetings with counsel, were there any specific documents you were shown?
A. We went over the -- certainly the two binders here which are the references that relate to my expert report. There were various other -- many, many of the documents from the reliance list.
I was shown some company documents.
There was -- we reviewed IFUs.
Q. So, the binders you referenced are the binders of literature you've got in front of you?
A. Yes.
Q. What company documents were you shown?
A. Testimony by, you know, certainly not comprehensive, by selected administrators in Ethicon and what they had to say about -- in their depositions

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or what they might have said in developing the products, some extracts of e-mails.
Q. So you were shown some deposition testimony?
A. Yes.
Q. You were shown some e-mail extracts?
A. Yes.
Q. Anything else?
A. No, I don't think so.
Q. Who selected the documents you were shown?
A. You know, I asked for a few things. I had -- I had -- I asked if -- you know, what documents, you know, have come under scrutiny in other depositions are the ones that I might want to look at, and counsel had some documents that she recommended I see.
Q. So counsel selected some of the documents and you selected some of the documents?
A. I said show me -- I said show me the good stuff and show me the bad stuff.

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Q. And then from there, it was selected by defense counsel?
A. It was kind of a combination of things I was curious about and things she thought would be relevant.
Q. So, I think the answer to my question is yes. Right? That defense counsel selected some of the documents you were shown?
MS. GERSTEL: Object to the form.
A. No. I think the answer is that I requested to see certain types of documents, and she selected others.
Q. That's the same thing.
Then there was another category of things you said you reviewed that you were shown.
What was it?
We had the binders, the internal documents. I believe there was something else you noted.
A. There were e-mails, some testimony. Looked at IFUs, which are

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company documents, a subset of the company documents.
Q. What e-mails were you shown?
A. There were some members of the development team giving opinions as to whether or not a mesh was stiff. There were some e-mails talking about whether a certain design of a sling might cause pain, should we be designing it that way.
It was a -- certainly a small subset of review as I was told the size of the company documents that existed and the testimonies that were weeks long. So it certainly was not comprehensive.
Q. These were e-mails and documents by Ethicon employees?
A. Yes.
Q. And what did the Ethicon employees have to say about the stiffness of the mesh?
MS. GERSTEL: Object to the form.
A. There was concern of differences between machine-cut mesh and laser-cut

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mesh, and if laser-cut mesh was stiffer, might it be an issue in planning for the products it was planned for use in.
Q. So, the Ethicon employees in the materials you reviewed were concerned about laser-cut mesh being stiffer?
MS. GERSTEL: Object to the form.
A. It was expressed as one of the concerns.
Q. And why were they concerned about the stiffness of mesh?
A. You know, there was conjecture that if it was stiffer, it might behave differently in clinical performance.
Q. So, your understanding of the e-mails you reviewed from the Ethicon employees was that they were concerned that stiffer mesh would lead to more complications.
Is that true?
A. I don't recall that wording.
I do recall them discussing whether it would have relevance to

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outcome, which of course would include efficacy and safety, but I don't recall specific wording that it would increase or decrease complications.
Q. So they were concerned about whether there would be more negative outcomes with laser-cut mesh because it was stiffer?
MS. GERSTEL: Object to the form.
BY MR. DeGREEFF:
Q. Is that your understanding?
A. I'm going to stick to my answer that they were concerned about whether it would change efficacy and safety. Safety would, of course, include any changes in positive or negative outcomes.
Q. Well, I mean, someone wouldn't be concerned about a positive outcome.
Right?
MS. GERSTEL: Object to the form.
A. You know, one of the things that I think is important to share is that when

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these e-mails are shared, it's an extracted e-mail from a sequence of discussions.
Q. Sir, that's not the question that's pending.
MR. DeGREEFF: We'll read my question back.
(The requested portion of the record was read by the Court Reporter.)
A. I think they would be concerned about a change that might be positive for the mesh as well as negative for the mesh.
Q. Okay. So, your understanding from those e-mails, just to make sure I understand what you're saying, is that the Ethicon employees were concerned about the efficacy and safety outcomes related to stiffness of mesh.
A. Yes.
Q. And then you said that you reviewed some e-mails from Ethicon employees related to whether a certain design -- related to certain designs of mesh.

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Is that correct?
A. Yes.
Q. When we're talking about laser-cut mesh, some of the TVT products we're here about today are laser-cut mesh.
Correct?
A. Yes.
Q. Which of the TVT sling products use laser-cut mesh?
A. The TVT-Exact and the Abbrevo are all laser-cut. The other two are laser cut, mechanically-cut. Some of it's geographic distribution and some of it's physician request.
Q. So the TVT and the TVT-O have both laser and mechanic-cut options?
A. Yes.
Q. So, the e-mails that you were reviewing related to the Ethicon employees discussing design of a product, can you tell me what your understanding was of those e-mails?
A. When the obturator, the TVT-O was being designed and developed, the

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questions, and there were e-mails discussing whether the passage -- the difference in passage would affect, you know, the leg or the groin. I do recall some discussions on that.

Q. Okay. So, the -- your understanding was that the Ethicon employees were discussing whether the transobturator approach would lead to increased groin pain.

Is that true?

MS. GERSTEL: Object to the form.

A. I think that was one of the concerns expressed in the e-mails, yes.

Q. What other concerns were expressed in the e-mails?

MS. GERSTEL: Object to the form.

A. I don't recall others that are coming to mind presently.

Q. And the transobturator approach is used by the TVT-O and TVT-Abbrevo.

Correct?

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A. Correct.

Q. Are you aware of literature concerning potential increased risks associated with the transobturator approach versus the retropubic?

MS. GERSTEL: Object to the form.

A. Yes.

Q. And what does that literature say? What are the potential increased problems?

MS. GERSTEL: Object to form.

A. The TVT-O has a higher increase in groin pain, which is usually transient. It has a higher increase in vaginal angle perforations. It has a less incidence in bladder injury and retropubic injuries.

Q. Is there a -- are you aware of literature saying that there's a two times greater risk of re-operation with transobturator placement versus retropubic?

MS. GERSTEL: Object to form.

A. You know, the articles that

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describe increased risk of operation need to be looked at individually because I'm aware -- the answer to your question is yes, but I can't confirm that being a legitimate statement because I have to look at the details of the article because they're very specific as to why they were re-operated on. And the data is mixed. There is not consensus data or data at a high level that suggests that the re-operation rate is two times greater with obturator, but there are reports.

Q. So you are aware of the literature stating that?

A. Yes.

Q. And is that literature contained in your reliance list?

A. There's a hell of lot of TVT-O literature in my reliance list. So I believe a lot of it is there, yes.

Q. The e-mails we just discussed by the Ethicon employees with regard to the laser-cut mesh or the transobturator placement, are those on your reliance

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list?

MS. GERSTEL: Object to form.

A. I'm trying to think if I have some. Let me just check.

(Pause.)

There are a number on the reliance list, yes.

Q. The internal e-mails we just talked about discussed within -- with Ethicon employees discussing laser-cut mesh and the transobturator approach, those are included on your reliance list?

A. I'm not aware of that. No, I don't think so.

Q. Did you see those documents for the first time in preparation for this deposition?

A. I don't -- I think I may have seen them prior to the TVT Retropubic deposition.

MS. GERSTEL: Dave, could I state for the record that as the reliance list was prepared by counsel, I believe those e-mails are on Dr.

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Lind's reliance list.
MR. DeGREEFF: I think you can probably take him through that stuff, if you want.
And you're welcome to state whatever you want for the record, obviously. But I'm interested in what he knows.
MS. GERSTEL: Okay. I just wanted to make clear that the company documents that were provided to Dr. Lind were put on his reliance list.
MR. DeGREEFF: Gotcha.
BY MR. DeGREEFF:
Q. So, the first time you looked at the e-mails we're discussing now was in preparation for your prior deposition on the TVT and the Gynecare?
A. Yes.
Q. So the first time you saw those was after you had already rendered your opinions?
A. I don't recall if it was before or after.

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Q. Do you recall seeing them before you gave your opinions?
A. I don't recall.
Q. Something you considered when you were giving your opinions?
MS. GERSTEL: Object to form.
A. If I had read them, then I considered it. And if I didn't, then I didn't. And I don't remember if I saw them before or after.
Q. You said you also reviewed some depositions in preparation for this deposition.
Do you remember what depositions you reviewed?
A. I don't remember specifically which one it was.
Q. Do you remember the subject matter?
A. I just asked to see a deposition that was on the multiple TVT products.
Q. Did you review that deposition in preparation for today?
A. Yes.

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Q. When did you review it?
A. Three weeks ago.
Q. And you don't remember who the person being deposed in that deposition was?
A. I don't.
Q. What about the TVT products were you interested in from that deposition?
A. I was interested in knowing what another expert did in discussing the products. I was interested in what counsel was interested in focusing on.
Q. So, was it another deposition taken by my firm?
A. I believe it was.
Q. Do you know who took the deposition?
A. Yes. It was Jeff Kuntz.
Q. Jeff Kuntz (different pronunciation)?
A. Kuntz.
I'm sorry if I mispronounced it.
Q. What in particular was it --
MR. DeGREEFF: Strike that.

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Q. Why did you need to see how another expert --
MR. DeGREEFF: Strike that.
Q. Was it a plaintiff's expert or a defense expert?
I assume it was a defense expert since we were taking it.
A. Yes.
Q. Why did you need to see how another Ethicon expert responded to the questions they were being asked?
MS. GERSTEL: Object to the form.
A. It's someone going through what I was going to go through. It seemed like a reasonable review method to hear what counsel had to say and take a look at what counsel had to say and see if I agreed with what the other person said, if I would have answered it differently.
Q. I mean, isn't the most important thing just for you to answer the questions honestly?
MS. GERSTEL: Object to form.

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A. Well, I think the importance is for me to get prepared in the best way I can to have the knowledge and at the same time answer honestly.
Q. So, the best way for you to get prepared to have the knowledge for this deposition was to read what another Ethicon defense expert who was being paid by Ethicon said in his deposition or her deposition?
MS. GERSTEL: Object to the form.
A. The best preparation was review of the literature, which constituted 99 percent of my time spent. So this was a small element.
Q. Is this the only deposition you reviewed in getting ready for your depo?
A. Yes.
Q. What about expert reports, did you review any expert reports in preparing for your depo?
A. I did not.
Q. Before we move on, let me ask

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this question.
With regard to the e-mails that we discussed where the Ethicon employees were discussing outcomes related to laser-cut mesh.
Do you agree or disagree with those employees?
MS. GERSTEL: Object to form.
A. I don't know the full context of where the e-mails were, and I don't know if they were in the middle of discussions of positives or negatives 'cause they're single pages. So I really can't comment on them.
Q. So you weren't shown the full document?
MS. GERSTEL: Object to form.
A. I wasn't shown the full thread of e-mails. They were just extracted pages.
Q. Who extracted the pages?
MS. GERSTEL: Object to form.
A. I don't know what was available to Ethicon and to counsel and whether I

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got everything that they had or whether some of it was extracted.
Q. But the documents you were provided by defense counsel to review were incomplete and did not contain the rest of the thread.
True?
MS. GERSTEL: Objection.
A. Some of them did and some of them did not.
MS. GERSTEL: Would it be a good time for a break? Or in the next few minutes.
MR. DeGREEFF: Sure. This works. Whatever.
(Recess taken.)
(Lind Exhibit 6, Curriculum Vitae of Dr. Lind, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. I've just handed you what I've marked as Deposition Exhibit Number 6.
Do you recognize that as your current CV?

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A. Yes.
Q. Sir, what kind of doctor are you?
A. I'm an obstetrician gynecologist with fellowship training in female pelvic medicine and reconstructive surgery.
Q. Do you have any board certifications?
A. I'm board certified in OB-GYN and I'm subspecialty certified in female pelvic medicine and reconstructive surgery.
Q. What states are you licensed to practice medicine in?
A. Just New York.
Q. Sir, if you look at there's a portion that says "Teaching Experience"?
A. Yes.
Q. In the teaching experience section of your CV, are any of the things listed there done on behalf of Ethicon?
A. The last one, the 2006 to present, the bio skills training labs, we set those up to teach our fellows, and

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there's usually an educational grant offered by each of the major companies that supply pelvic floor products that usually pick up the cost for the lab. So some of those are supported. They probably would have been between 2006 and 2010, some labs that were supported by Ethicon.

The rest of them are mostly academic courses that were at a facility and supported by the facility.

Q. Okay.

So, would Ethicon have -- when you say "supported," you mean paid for.

Right?

A. They cover the cost of the lab, the cadaver lab for the day. We would not be getting paid for that lab, but they're picking up the expense of cost to use cadavers to teach.

Q. What is the cost to use cadavers to teach?

A. A lab could be $30,000.

Q. Each lab?

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A. Yeah. The cost for the cadavers and the people who prepare them, maintain them and dispose of them is very high.

Q. And Ethicon would pick up one of the --

MR. DeGREEFF: Strike that.

Q. How many of those cadaver labs per year would Ethicon pick up?

MS. GERSTEL: Objection.

A. They probably do one a year in the general teaching sense.

Q. For four years or so, is what you're saying?

I guess how many years did they do that?

A. Yeah, four to six years.

And the other companies would do the same. We have a lot of teaching labs. So Boston Scientific would pick up a lab. Caldera would pick up a lab.

Q. Okay.

So, I mean, Ethicon would have spent 120 to $180,000 on cadaver labs --

A. Yeah.

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Q. -- based on what we just talked about.

Is that correct?

A. Yes.

But I would like to specify that it was the hospital rules and compliance that they would have to have absolutely no input as to the material, slides, things taught, and the products are not exclusively theirs. They were everything that we think the students and fellows need to learn.

MR. DeGREEFF: I'm going to move to strike that, and I'm going to ask my question again.

My question was pretty simple. It was just a yes or no.

Q. Ethicon would have spent 120 to $180,000 on cadaver labs, based on our discussion?

True?

MS. GERSTEL: Object to form.

A. Across those several years, yes.

Q. There's also a list of lectures.

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I guess the title is "Lecture Presentations," on your CV.

Do you see that?

A. Yes.

MR. DeGREEFF: Strike that. Before I do that, let me go back.

Q. Who was teaching these cadaver labs that were funded by Ethicon?

A. My division, which would be myself and my partners.

Q. Would Ethicon fund these cadaver labs at the request of you and your department?

A. Yes.

Q. Now are the lecture presentation section of your CV.

Do you see where I'm at?

A. Yes.

Q. Were some of those lectures done on behalf of Ethicon?

A. The ones listed here are all invited lectures in academic only situations and not for Ethicon.

I don't have listed here invited

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Ethicon lab experiences where I taught at their Ethicon teaching experiences.
Q. Does the lecture presentation section include lectures given on behalf of any transvaginal mesh manufacturer?
A. No.
Q. Why did you not include in your lecture presentation section those that were done on behalf of transvaginal mesh manufacturers?
A. I guess when I'm writing an academic CV, I'm thinking about my academic presentations. And those were in a consultant role, so I didn't include them.
Q. What is the difference between the lectures you gave in a consulting role versus those given in an academic setting.
A. These were advised by me or offered to institutions for teaching purposes only or invited because of my expertise to give teaching, and the others were labs we set up to teach, for which we couldn't have the setting of fresh

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cadavers without the backing of companies because we didn't have the money for the labs.
And it was a unique teaching situation. It was really access to the cadavers was the key teaching element. So it was more of a -- it was less of a lecture than the opportunity to execute procedures in a unique way that had really not been done before to be able to do them on fresh cadavers.
Q. Well, when you're giving lectures as a consultant for Ethicon, you were being paid.
Right?
A. Well, let me make a distinction.
The labs that we're talking about where I'm teaching at my lab center, I'm lecturing on whatever I want for pelvic reconstructive surgery on various procedures. Some of the procedures have nothing to do with mesh or any product and others do.
And in the discussions of mesh

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products, there is not any selection for that lab when Ethicon's paid for it that discusses theirs only. It's we describe everything we use for the reasons we use them. So we presented it in a non-biased way.
Q. What you just gave the explanation about, that's what you're referring to in the academic setting.
Right?
A. The academic setting in my lab. Now, the distinction that will also put it into a teaching category is when Ethicon wanted to teach the procedures, each of these slings or the mesh procedures and they wanted expert surgeons to help train people on fresh cadavers. That would be a different teaching setting which I would say is teaching-slash-consulting.
Q. Right.
When you're giving lectures as a consultant, you're being paid by Ethicon pursuant to the consulting agreements you signed with them.

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Right?
A. Yes.
Q. And they have input into the materials you're using for those lectures.
True?
A. I did not permit that.
Q. Well, contractually under consulting agreement, they have the right to have input into those materials.
Correct?
MS. GERSTEL: Object to the form.
A. They could have input, but I control the slides.
I would never accept a company's slide deck, and I never did.
Q. Those two things, i.e. being paid and -- being paid by Ethicon and Ethicon's right to review and have input in your materials, those aren't present in the academic setting.
Right?
A. Correct.
Q. You have a bibliography section

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on your CV. I'm sure you're aware of that.
Right?
A. Yes.
Q. Have you published any peer-reviewed articles regarding any of the Ethicon mesh slings?
A. No.
Q. Have you published any peer-reviewed articles concerning mesh slings regardless of the manufacturer?
A. We contributed cases to a Solyx study, which was published.
Q. Was it peer-reviewed?
A. Yes.
Q. And were you the author, or did you just contribute in some other way to that?
A. I was a co-author. I was not the lead author.
Q. And which one was the -- on your bibliography was that particular article?
A. On the second page, it says Nosseir S, Serels and Lind "Safety and

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efficacy of the Solyx single-incision sling."
And then we had another -- we had a poster presentation, which is peer-reviewed for acceptance as a poster, but it's not a -- published in a journal a little further down by the same group.
Q. And those were both with regard to the Solyx?
A. Yes.
Q. Any others? Any other peer-reviewed articles related to mesh slings that you published?
A. We did on the third page. You can see the first name Shalom where it says "Visualization of synthetic mesh utilizing optical coherence tomography." That wasn't efficacy or complications of mesh, but it was -- what we thought we were trying to do there was, you know, special optical tomography device that would let us find the sling and we thought it might be useful for it when you have to go back and note a little more precisely

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where the sling is.
Q. So that would be useful for when people were having complications and you needed to look at the sling?
A. Yes.
Q. Were these two Boston Scientific articles that you discussed that were peer-reviewed, were they funded by Boston Scientific?
A. They were.
Q. They were?
A. Yes.
Q. Do you remember how much you were paid for your work on those?
A. I do not, but I do -- I can clarify that the funds would go to a research fund and in no way would remunerate me financially.
Q. Was there any other of your articles in your bibliography that were funded by transvaginal mesh manufacturers?
A. On the second page it has Cholhan and Lind, the "Prepubic Approach to Mid-Urethral Slings." That was funded

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by Boston Scientific.
Q. Okay.
A. I'm scanning the rest of them.
(Pause.)
No others.
Q. On the articles that you worked on that were funded by transvaginal mesh companies, did you do a disclosure of conflict of interest?
A. Yes.
Q. What is the purpose of disclosing that an article was funded by a mesh manufacturer?
A. Well, both at the point of patient consent and at the point of publication, the disclosure allows the readers to understand that there was a financial support by a company that has relevance for the result of the study. A reader can decide whether that financial disclosure introduces bias and judge that as to whether or not to credit the study more or less based on that.
Q. When someone receives funding or

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payment from an entity, there's potential bias that can result.
True?
A. There's the potential, yes.
Q. How do you define bias?
A. Bias is when a -- in the setting of a study, when you're interpreting a study or how you're handling your patients or how you're looking at results, you have a feeling or an impetus to want it to go in one direction or another that may not be objective. That's if you're not handling it properly.
So, if you had bias and you were not able to resist bias in a study, you would be influencing the study in one way or another because there was financial support.
Q. I think you put it very well in another deposition I saw that you gave.
Bias is -- would you agree that bias is anything that affects the objectivity of the outcome of a study?
A. Sure. That's one way of looking

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at it.
Q. One of the things that could affect the objectivity of a study is funding or payment.
True?
A. It could, but there are defenses against that.
Q. Which, if any, of the articles on your bibliography are relevant to the TVT sling products?
MS. GERSTEL: Object to form.
A. Well, I think I've got a lot of --
MR. DeGREEFF: Strike that.
Let me ask that in a more fair way. That was a pretty broad question.
Q. Do any of the articles in your bibliography relate to or address any of the TVT products?
A. I think they're not directly studies on TVT products, but I think they're products on -- they're studies on incontinence procedures which are relevant

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to how TVT fits into the incontinence surgery products history.
I have a number of mesh studies which are relevant to procedures with mesh, whether they're prolapse procedures or incontinence.
Q. Well, the TVT products are not for prolapse.
Correct?
A. Correct. I was indicating that the behavior of the same type of mesh would be relevant to, in a broader scope, how mesh behaves.
Q. I think you answered this, but let me just confirm because you said it in a better way than I did.
None of the articles included on the bibliography are on the TVT -- any of the TVT sling products.
Correct?
A. Correct.
Q. So you have not been direct -- you have not been involved directly in a published study of any kind related to

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the, or about the TVT products?
A. Correct.
Q. What are some alternatives to slings?
MS. GERSTEL: Object to form.
A. There are, historically, there are dozens and dozens of stress incontinence procedures. They include Burch, needle procedure, Pereyra, Stamey, pubovaginal slings, amongst others.
Q. Which of the native sling --
MR. DeGREEFF: Strike that.
Q. Which of the alternatives to mesh slings are still in use today?
A. The pubovaginal slings are still in use. The Burch is still in use, but to a much lesser degree, markedly lesser degree than previously.
Q. Biologic slings?
A. They are used by a small number of users. They're certainly not a dominant.
But in answer to your strict question, yes, those are still in use.

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Q. And those alternatives are used for the same indications as the TVT mesh slings.
True?
A. Yes.
Q. Have you ever performed the Burch procedure?
A. Many, many times.
Q. Do you still perform it?
A. Yes.
Q. How many times have you performed it?
A. In my career, 300, 400.
Q. When was the last time you did one?
A. Within the last few months.
Q. How many have you done this year? Any idea?
A. Three or four.
Q. What about have you ever done the native tissue sling procedure?
A. Yes.
Q. Do you still do it?
A. I do.

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Q. How many have you done?
A. I did two this year.
Q. How many have you done in your career?
A. 50 to 60.
Q. What about the biologic slings, have you ever used one of those?
A. I did not.
Q. The Burch procedure and the native tissue repair are still viable alternatives to the TVT mesh slings that are still being used.
Right?
MS. GERSTEL: Object to form.
A. Can you just restate that?
Q. The Burch and native tissue slings are still available alternatives that are still in use to the TVT slings.
Fair?
A. Yes.
Q. Sir, are you involved in any current research on polypropylene meshes?
A. We have a -- I'm not a co-author on it, but we have in our division, we

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have some rabbits being implanted with absorb -- partially absorbable and absorbable mesh to analyze the biochemical and histochemical changes during implantation.
Q. Are you involved in that at all?
A. I'm involved in the chat in our research sessions. They're not my project. I'm not the mentor or co-author on them. But since it's in the division, every Friday we go over products. So I'm privy to the updates and the ongoing happenings on it, but I have no ownership on that project.
Q. So you're not -- you've had some conversations about the project, but you're not involved in actually administering the project.
Fair?
A. Correct.
Q. Is that project being funded by a pharmaceutical company -- or, excuse me. A medical device company?
A. It is. It's being funded by a

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mesh company.
Q. Which one?
A. I don't know the name.
Again, I'm kind of peripheral on this one.
Q. Okay.
Is it Ethicon?
A. It's small. It's not one of the well-known companies.
Q. Have you ever written a peer-reviewed journal article on polypropylene mesh?
A. Yes. I have a publication on the reduction of the analysis of mesh complications with abdominal sacral suspension done in different ways for abdominal sacral suspension analyzing erosion rates.
Q. What product was at issue?
A. Gynemesh.
Q. Not the TVT products?
A. No.
Q. Have you ever written on the Burch procedure?

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A. Yes. I have a couple of publications in my CV.
Q. Were those peer-reviewed?
A. Yes.
Q. What was it, do you remember the subject matters you were writing about?
A. The Burch procedure requires a fairly good size incision, and I was instrumental in designing a device that would allow suturing in a very small space. So once the device was approved, I wrote a paper on about 90 patients to see whether a Burch could be achieved in a much smaller incision because with the use of the suturing device, it would facilitate the suturing without needing as much space for visualization. So the goal was to see if I could take a Burch and make it less invasive with an incision that was less than half the size.
Q. And what were the results?
A. They were excellent. We achieved it.
Q. So you came up with a way to

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make the Burch a less invasive procedure?
A. Yes.
Q. Do you have a patent on that product?
A. I do not.
Q. It feels like there's more to that story.
Does someone have a patent on it?
A. I -- the rules for -- someone has a patent on it, and I was offered part ownership to it. My academic affiliation and the roles for ownership of intellectual property were such that taking the intellectual property would be a poor financial decision.
Q. Gotcha.
A. So I just came on as a consultant and continued to help them develop the device.
Q. Which medical device company was developing it?
A. It was the Laurus Corporation, L-A-U-R-U-S. And we developed it with

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them and they patented it, and I did a lot of -- most of the studies to show how it would work and the efficacy and safety.
And I wish I had a part ownership because they sold it to Boston Scientific for a nice penny.
Q. So, is that device currently in use today?
A. Yes, it is.
Q. And when did that device get developed?
A. I was working on it from '94 to '96, and I think it got sold to Boston Scientific in '96.
Q. And the end result was that the Burch procedure, which was an alternative to the TVT mesh slings, became less invasive.
True?
A. That, as well as a few vaginal procedures that we also had trouble suturing with. It had more than one application in addition to the Burch.
Q. Were all three of those articles

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related to that same issue?
A. I think there were two on the in-line suturing device. Yes, they were on the issue of -- did I do sacrospinous?
I think one might have been Burch and one might have been sacrospinous suspension. I can check on that, if it matters.
Q. Yes. I think you said three. That's why I was asking.
(Pause.)
A. There's two. One looked at it for the use in sacrospinous suspension. The other one looked at it for the use in Burch.
Q. Okay.
And what were the findings on the sacrospinous suspension?
A. The procedure was able to be performed with less dissection and in less operative time with good efficacy and minimal to no complications. So it didn't add any adverse effects, and it lessened the dissection and operative time.

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Q. And is that also a -- is that procedure also a sling alternative?
A. No. That's for pelvic prolapse. That's for vaginal apex prolapse.
Q. Have you ever written anything on the biologic tissue slings?
A. I have not.
Q. Do you consider yourself an expert on chemical engineering?
A. As it relates to slings, yes.
Q. And what is the basis? Why are you an expert in chemical engineering?
A. Because the issues related to chemical engineering as it pertains to tissue interaction with mesh and implants has been part of my career studying, implanting, taking care of patients, insuring their safety and observing the behavior. So that's 25 years of experience.
Q. Do you have any education in chemical engineering?
A. I read quite a bit of literature on the behavior of the mesh and how it

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interacts with tissue. So my education is based on independent review of the literature.
And I do not have a Ph.D.
Q. Well, I think we're talking about two different things.
Are you talking about biomaterials right now versus chemical engineering? True?
A. Whether it's chemical engineering or biomaterials, how they relate to the behavior of slings implanted in patients, I consider myself an expert.
Q. You don't know anything about the chemical engineering of polypropylene mesh itself.
True?
A. I would say that's false.
Q. Okay. Why is it false?
A. Because I've read articles about the process of it coming from resin, how it gets transformed from resin, and how it gets made into fibrils and how it gets made into the decision to how the fibrils

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get made and the width of the fibrils. So I've done reading on how they take it from powder and resin and transformed into materials and the reasons why they make decisions.
Q. So, is it your testimony that reading articles about how they make transvaginal -- excuse me. Polypropylene mesh is why you consider yourself a chemical engineering expert?
A. Reading articles, seeing the different outcomes of how the chemical engineering goes into making products different and seeing how it behaves in patients and seeing the outcomes for 25 years is my basis for stating I'm an expert on that topic as it relates to mesh in sling behavior.
Q. And you've seen all of that in your role as a physician.
True?
A. Yes.
Q. No one's ever hired you to be a chemical engineering expert.

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Right?
A. No.
Q. No one's ever hired you as a chemical engineer.
Right?
A. Correct.
Q. When you hang your degree on the wall, it doesn't say chemical engineer.
Right?
A. It does not.
Q. Do you consider yourself an expert in pathology?
A. As it relates to the behavior of sling and mesh implanted in patients, yes.
Q. In your daily practice, what is it that makes you a pathology expert?
A. The rabbit studies that we're doing produce pathology slides which we examine for various histochemical properties, tensile strength and mechanical properties, and this is a routine part of the research that our group does.
Q. You mean the rabbit studies that

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the other people in your group are doing.
Is that what we're talking about?
A. To distinguish though what the other people are doing is I play a role in responding and advising what would be studied, how they're doing the study, response on whether how they're getting the information is correct, whether the staining processes are correct. So I'm involved in the study more than just listening.
Q. You're not an author on that study.
Right?
A. I am not.
Q. You are not a co-author on that study.
Right?
A. I'm an advisor on that study, and I'm part of the education discussions on the process.
Q. You are not administering the study.

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Right?
A. No.
Q. I'm correct you're not administering the study.
Right?
A. Correct.
Q. You don't even know who the pharmaceutical company is that's funding the study.
Fair?
A. That's correct.
MS. GERSTEL: Object to form.
BY MR. DeGREEFF:
Q. Other than that, the rabbit studies, what qualifies you as an expert in pathology based on your daily practice?
A. When I review the literature, I'm aware of many articles about excision of specimens, what they look like, how people's opinions and how the pathology's been studied on excised specimens, is there inflammation, is there ingrowth, is there degradation. So I'm very well-versed on the literature related to

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pathologic specimens of mesh and sling material.
Q. Do you actually read the histopathologic slides?
A. In the studies that we do, I look at the pictures along with our study group, yes.
Q. You're talking about the rabbit thing again.
Right?
A. Yes.
Q. Do you actually review histopathologic slides out of humans as part of your practice?
A. I do not.
Q. You just read the reports that come to you from the pathologists.
Right?
A. Correct.
Q. Have you read any pathology reports related to excised mesh?
A. I think the Clave study is one of the studies that gets into that.
Q. I mean in your daily practice.

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Have you reviewed reports, pathology reports from the pathologists, related to mesh that was removed from --
A. Yes.
Q. -- patients?
A. Yes.
Q. When you review those reports, do they discuss inflammation of the tissue?
A. Sometimes inflammation is mentioned, yes.
Q. Do they discuss scar plating related to the mesh?
A. I have not read that on a pathology report.
Q. Do they discuss degradation of the mesh?
A. I have not read that on a pathology report.
Q. What is the -- inflammation can lead to pain for a woman.
True?
A. Yes.
Q. And it can lead to chronic pain.

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Right?
A. It can, yes.
Q. And mesh leads to tissue --
MR. DeGREEFF: Excuse me.
Strike that.
Q. Mesh can cause tissue inflammation.
True?
MS. GERSTEL: Object to form.
A. It -- I would say the mesh itself doesn't cause inflammation, but it could potentiate inflammation.
Q. Mesh itself can cause a foreign body reaction.
True?
A. Yes.
Q. And that can lead to inflammation?
A. True.
Q. Do you consider yourself an expert in polymer chemistry?
A. As it relates to mesh and slings, yes.
Q. This is amazing. If you come up

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with a yes for that, we're -- okay.
What is your background in polymer chemistry?
A. My answers would be the same as I replied previously for my background for --
Q. Okay. So, your answer to -- I just want to make sure anything I asked you about chemistry or chemical engineering, your answer is going to be I've read articles on polypropylene mesh and I listen to updates on the rabbit study.
Right? Those are the two things?
MS. GERSTEL: Object to form.
A. No. I would expand on that.
Q. Okay. What else?
A. For 25 years, I've implanted mesh. I've looked at explanted specimens and pathology reports. I have studied the literature. I've read literature, both positive and negative, on various engineerings, polymer chemistry and other

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aspects of scientific ways that you can analyze what happens to mesh. I am participating in a lab that implants mesh, excises mesh, testing it for tensile strength, looking at it under a microscope for various inflammation and histochemical changes, and I've been studying this and been participating in educational and clinical and pathology education for 25 years.
Q. That all makes you a doctor, right?
A. No. I'm stating that that makes me an expert.
Q. What is your degree in?
A. I have an MD.
Q. Okay.
What is your undergraduate degree in?
A. I have a bachelor of arts.
Q. Do you have any educational training related to chemistry or engineering?
A. I have 25 years of additional

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education as described previously.
Q. What you described was 25 years of being a doctor, right?
That's what you're relying on for being a chemist and an engineer?
A. That was not my answer.
MS. GERSTEL: Object to form.
BY MR. DeGREEFF:
Q. I'm asking you also consider yourself a biomaterials specialist based on all the stuff we talked about?
A. Yes.
Q. Any other reasons?
A. I think we've gone through them.
Q. That's all of them?
I'm just making sure there's not anything else.
A. On biomaterials I think you certainly can say in that area, I have published and tested things on my own, published them and participated in advising and testing in cadaver labs and published materials on my own. So my additional evidence of expertise is

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stronger in that area.
Q. Have you ever published any opinions that polypropylene mesh does not degrade in the human body?
MS. GERSTEL: Object to form.
A. I haven't published it.
Q. Do you consider yourself an FDA expert?
MS. GERSTEL: Object to form.
A. I'm distinctly aware of FDA matters and paperwork as it relates to mesh products and Ethicon mesh products and the rules that go into IFUs.
I would not say I am a comprehensive FDA expert.
But I would say, as it relates to the matters in this case, I would say I've reviewed the pertinent documents and are comfortably familiar with that.
Q. What are the pertinent documents?
A. There's a Blue Book memo and a second FDA document that describes what's required in the release of a product, what

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has to be on labeling, what has to be included in adverse events, and as it relates to this particular, you know, issue at hand is what adverse events are necessary to be included in an IFU.
Q. Because it sounds like you're not claiming you're an FDA expert. You're claiming you're an IFU expert.
Right?
MS. GERSTEL: Object to form.
A. I claim to be an FDA expert as it relates to adverse reactions and the rules necessary and laid out as to what needs to be included.
Q. How did you become aware of --
MR. DeGREEFF: Strike that.
Q. Under what circumstances did you review these FDA materials related to Ethicon products?
A. Well, in discussing with counsel became clear that, you know, what warnings are in the IFU is of quick relevant to these cases and I said I'd like to see the FDA documents that dictate the rules.

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Q. Was that before or after you gave your opinions?
A. That was before.
Q. So, what you're claiming makes you an expert on the FDA is materials you reviewed in preparing for to be a litigation expert for Ethicon.
Is that right?
A. Well, if someone were to ask me if I'm an expert in FDA in the broad sense of the word, the general everything that they take care of, I would say no.
If I'd say as it pertains to the relevant issues to the materials involved in this case, I would say I have very thoroughly read through the relevant documents and therefore consider myself an expert as it relates to mesh products and adverse warnings and what needs to be included.
Q. Did you read the 510(k) submission for this product?
A. At some point I did.
MS. GERSTEL: Object to form.

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BY MR. DeGREEFF:
Q. Did you read all the testing submitted with the 510(k)?
MS. GERSTEL: Objection.
A. I don't know if I read all of the testing. I think I was made familiar with some of it.
Q. Do you know the difference between clearance and approval of a product?
A. There are different pathways to go through the FDA. There's a 510(k) pathway, which is based on a precedent, and then there's another pathway where based on data, it's you go through based on your own merit and data.
Q. What's the other pathway called?
A. I don't know.
Q. Does 510(k) end up with approval or clearance in the end?
A. Approval.
Q. Would you be surprised to find out that 510(k) ends up with clearance?
A. I'm sorry.

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Q. Would you be surprised to find out that 510(k) ends up with compliance, not approval?
MS. GERSTEL: Object to form.
A. I may have that vocabulary confused.
Q. As a FDA expert, do you think you should probably know the difference between clearance and approval?
MS. GERSTEL: Object to form; argumentative.
A. I think the key elements here are what the rules are for what needs to be included in an IFU, and I don't think the rules of what the vocabulary term is for approval versus otherwise is the key element.
So no, I wouldn't consider that eliminating myself as an expert to the relevant materials.
Q. What I'm taking what you're saying is that you do consider yourself an expert on warnings?
A. Yes.

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Q. What risk information are medical device companies required to put in their IFUs?
A. They're required to put in the most common and adverse reactions that are unique to the product, and they are not required to put in things that are commonly known.
Q. What industry standards govern warnings in medical devices?
MS. GERSTEL: Object to form.
A. The FDA.
Q. What are the various sections of the regulations that relate to warnings for IFUs?
MS. GERSTEL: Object to form.
BY MR. DeGREEFF:
Q. And for the record, you're currently looking to your report to give you that answer.
Correct?
A. That would be correct, because I can't always memorize that it is 21 CFR 801.109(c) and device labeling guidance number G91-1. So at times I may have to refer, since I haven't memorized everything that exists in all of these binders in my report.

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Q. You think an FDA expert on warnings would know that?
MS. GERSTEL: Object to form; argumentative.
A. I think an FDA expert on the entirety of the FDA would know that, but that does not exclude me from being an expert on the areas that I previously described.
Q. What departments of a medical device company are involved in creating warnings?
A. When I have participated on discussions about what should be included, there's research and development, there was regulatory, and there was compliance.
Q. Have you ever read any testimony from Ethicon employees regarding Ethicon's position on what belongs in an IFU?
A. I don't recall.

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Q. Have you ever drafted an IFU for a medical device?
A. I didn't draft it.
I participated in discussions about what should be included and what shouldn't.
Q. What was your participation?
A. It was in -- with Boston Scientific in releasing a few of their products.
Q. Which products?
A. It was the Advantage and then it was their Prolene mesh for sacral suspensions.
Q. Did they pay you to do that?
A. Yes.
Q. How much?
A. Whatever my hourly was then. It was a little lower, $300 an hour.
Q. How many hours did you spend working on that IFU?
A. Probably two expert sessions. I would say twelve.
Q. Was that like a roundtable

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discussion about what kind of warnings should be in the IFU?
A. Usually was -- it usually was a couple of hours in the lab, then followed up by roundtable discussion.
Q. Was the purpose of the lab to test out the implant, how it worked with the implant of the device?
A. Correct.
Q. And after you made your recommendations, you didn't have any involvement in the actual drafting of the IFU?
A. I did not.
Q. Do you agree that physicians should be made aware of the significant safety risks with a product in the IFU?
MS. GERSTEL: Object to form.
A. Well, the definition of significant is -- requires a larger discussion than a yes/no question.
Q. How do you define significant?
MS. GERSTEL: Object to form.
A. I would define it as I did

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before, where they have to describe the most common and unique adverse reactions to the product, but they don't necessarily have to provide -- list adverse reactions that are commonly known.
Q. Have you ever read the deposition of Ethicon employee Catherine Beef [ph]?
A. I have not.
Q. Is that something that's on your reliance list?
A. I'm not -- I don't recall seeing that. I don't know if it's on the reliance list.
Q. If it was her testimony that physicians should be made aware of all significant safety risks associated with a product in the IFU, is that something you disagree with?
MS. GERSTEL: Object to form.
A. Yes, I disagree.
Q. Do you agree that the manufacturer of a medical device that's going to be implanted in a woman's body is

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required to disclose all significant risks to doctors that come with the use of the device?
MS. GERSTEL: Object to form.
A. No.
Q. You do not agree?
A. I do not agree.
Q. Were you ever provided the deposition of Ethicon's medical director Dr. Weissberg?
A. I don't recall it.
Q. If the medical director testified that that's the case, do you disagree with Ethicon's medical director?
MS. GERSTEL: Object to form.
A. Yes.
Q. The warnings and adverse reactions section should include all significant risks and complications related to the use of the TVT products.
Do you agree?
MS. GERSTEL: Object to form.
A. Did your statement say "all"?
Q. Yes.

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A. I disagree.
Q. Have you ever read the deposition of Ethicon's medical director Dr. Robinson?
A. No.
Q. If that was the testimony, do you disagree with it?
A. I disagree with it.
Q. Do you agree that doctors rely on medical device companies, such as Ethicon, to tell them whether the products they manufacture are safe?
MS. GERSTEL: Object to form.
A. I think the company provides a small piece of a doctor's understanding and learning if something is safe. It's not the major role at all.
Q. So you believe they rely on them in part for that information?
A. Correct.
Q. Do you agree that doctors rely on medical device companies, such as Ethicon, to investigate and test the safety of their products before putting

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them on the market?
MS. GERSTEL: Object to form.
A. I think that they are interested in testing prior to release, yes.
Q. Is that something that you as a physician want the medical device providers to do?
A. Yes.
Q. Do you agree that the company knows more about the design features and potential risks of their products than physicians do?
MS. GERSTEL: Object to form.
A. In the early development stage, I would agree with you, and then when it's out there, I would say there's -- you know, the doctors had the ones putting it in, seeing how it behaves and seeing the patients. So there are -- I think that changes. I think it -- I think it changes and the doctors can become more expert as to efficacy and safety of the device and how the features are panning out than the companies who make it.

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Q. The physicians are not privy to the results of the testing and studies that are done by the company prior to putting the product on the market.
True?
MS. GERSTEL: Object to form.
A. They're privy to some of them. When you have the -- typically the lead inventor or authors gather data, they're usually privy to that. When a company would approach me with a product, first thing I'd say is can you show me the data you have on it, and they would share that. So I am privy to the data they have.
They typically would not go through all of the R&D bench testing, and some other items would not be included in that.
Q. Right.
Doctors would not be privy to the bench testing results done by a medical device company, such as Ethicon.
Right?
MS. GERSTEL: Object to form.

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A. It's not routinely offered, but there are certainly many times where I've asked for that type of information and it's been disclosed readily.
Q. But you had to ask for it.
True?
A. Yeah. Yes.
Q. Do you agree that if there's reasonable association between a product and an adverse event, a company should disclose that information?
MS. GERSTEL: Object to form.
A. You know, the reasonable association specification in your question stumps me a little bit because it depends. It's really -- there's a continuum of how much information they get. And at a certain point, if there's a very, very strong relationship between a product and an adverse event, yes, I think it should be disclosed, but there's really a continuum between how much they know and when that should be shared.
Q. Okay.

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So, would you agree that the information that a medical device manufacture, such as Ethicon, includes in its IFUs should not be misleading?
MS. GERSTEL: Object to form.
A. I could agree with that.
Q. Do you agree that the information a medical device manufacture includes in its IFU should have a scientific basis?
MS. GERSTEL: Object to form.
A. I think it has a scientific basis, as well as a clinical experience basis in terms of the things that are commonly known.
Q. So it should be a scientific and clinical basis?
A. I think so, yes.
Q. And a medical device manufacturer should put the safety of its patients first.
True?
MS. GERSTEL: Object to form.
A. Yes.

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Q. Even above profits.
Fair?
MS. GERSTEL: Object to form.
A. Yes.
Q. Do you agree that a medical device company, such as Ethicon, is required to make its products reasonably safe?
MS. GERSTEL: Object to form.
A. Yes.
Q. Lastly, do you agree that if a medical device manufacturer sells two products that do the same thing, the medical device manufacturer should stop selling the less safe product and only sell the safer product?
MS. GERSTEL: Object to form.
A. The evidence and the data distinguishing those adverse events would need to be compared to get to a point where it was convincing that one of them definitively was as efficacious and/or safer.
So, it's a -- it depends on the

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level of evidence.
Q. Let me ask my question again.
Do you agree that if a medical device manufacturer sells two products that do the same thing, that the medical device manufacturer should stop selling the less safe product, assuming it's definitive, and only sell the safer product?
MS. GERSTEL: Object to form.
A. I can't agree with that because there are situations where something has a higher risk, so let's say for example leg pain with an obturator sling. It's the better choice, even though if you -- just looking at data as a higher risk of thigh pain or leg pain, it's the better choice for a patient because the patient may have retropubic problems or cancer there or radiation there or hernia there. So it now becomes the better choice. So if you're just looking at the data, you'd say well, higher leg pain, maybe we shouldn't use it. But having the two available lets

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you go the two different routes, and based on patient's anatomy and doctor's backgrounds, they may be safer in different doctors' hands and they also may be safer based on the patient's previous surgery history.
Q. So you can't answer my question as asked, is what you're telling me?
A. No, I cannot.
Q. Have you ever read the deposition of Dr. Holste?
A. No.
Q. Was that ever provided to you by the defense for review?
A. Not that I recall.
Q. If that was the testimony, do you disagree?
A. Yes.
Q. Are you an expert on the design of medical devices?
A. I think I am.
Q. And what qualifies you as an expert on the design of medical devices?
A. Well, I made a really awesome

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suturing device that allowed people to suture in really small places and made a whole bunch of other people millions of dollars. And it's really cool and it required some really neat engineering.
I think I have a unique appreciation for the very significant angles and spaces we're in in pelvic surgery.
I think I have an intuitive thought process as to how to think of things that might let us do things more easily.
I understand research design and how to test things properly.
I think I have shown in my body of work the ability to test meshes and figure out how to decrease erosions, how to suture in small places. And I think I've spent 25 years thinking about the design of instruments and have a pretty good background.
Q. Have you ever designed a transvaginal mesh product?

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A. I've proposed some and some are under consideration, but none are presently being adopted or funded for production.
Q. Have you been --
MR. DeGREEFF: Strike that.
Q. Have you designed any mesh slings?
A. The innovations that I have in mind, which, you know, presently have been proposed to a couple of engineers and to a couple of companies, they have less to do with the sling than with the trocar introduction, and so it's part of the sling system, but it's not the mesh itself. I would say the group that we're working with, of course, my practice, you know, as the role that I play in that process, you know, it's a very close division. I've definitely got my eye on how absorbable meshes are going to behave as we continue to study them.
Q. So, what are the changes to the trocar that you've made in these new

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devices that you've designed?
A. I'm going to have to say that's confidential.
Let me just clarify that to give you something.
I think that we -- sometimes when you pass a trocar and you did cystoscopy because you want to see if the pass went into the bladder and sometimes it's missed even though trocar looks pretty big under cystoscopy. So I have a design proposal that would decrease or eliminate the chances of missing a very small passage into the bladder.
Q. What weight of mesh do you use in the -- in your new products?
A. I haven't gotten to the point of choosing the mesh. I'm only designing the trocar. So the mesh would be -- there's two companies it's proposed to, and the mesh would be whichever company decided to move this forward, I'm comfortable with both of their sling products. So you have both Caldera and Boston Scientific looking

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into this. So it would be their meshes and it would just be changing the trocar insertion.
Q. What weight of mesh do Boston Scientific and Caldera use?
A. I don't have their mesh weight by memory. They're all type 1 wide pore mesh.
Q. Why did you not go to Ethicon for their mesh?
A. I've had a closer working relationship with these two companies for the past five, six years.
Q. Does the Ethicon product have smaller pore mesh than BSC and Caldera?
A. They're pretty close. I think Caldera is less, is smaller. I don't recall where Boston Scientific is related to TVT.
Q. Well, Caldera is actually larger pore mesh than the Ethicon product.
Correct?
A. I'm not sure about that.
Q. What about BSC is actually a

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larger pore mesh than Ethicon mesh too.
Right?
MS. GERSTEL: Object to form.
A. I don't have those comparisons in my head.
What I know is that they're all in the order of ten times wider pores than what is felt to be the minimum necessary for favorable characteristics as described by AMA.
Q. Regardless, when you decided you needed mesh for a product you're developing, you sought that mesh from Caldera and Boston Scientific, not from Ethicon.
True?
A. I wasn't seeking mesh. I was seeking someone who thought an introduction needle had an advantage.
Q. Okay.
The two companies you went to for your product were Caldera and BSC, not Ethicon.
True?

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A. Yes.
Q. And you could have gone to whatever companies you wanted to.
Right?
A. Yes.
Q. And you had a working relationship with Ethicon.
Right?
A. Yes.
Q. When was this that you were approaching these companies?
A. In the past two years.
Q. So you had a relationship with the company in Ethicon that has paid you 200 to $250,000 as a litigation expert.
Right?
MS. GERSTEL: Object to form.
A. Yes.
Q. Has Ethicon ever asked you to consult on the design of any of their mesh products?
A. I was in a consulting R&D session on whether or not to make the trocar smaller when they were considering

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the TVT Exact. So that's not a mesh decision, but again part of the mesh system. I know they were interested in what I thought of the Gynecare mesh just because I had used it a lot. So, it wasn't -- the Gynemesh had been, you know, a smaller cut piece of a previous type of mesh they had previously used. So they were interested in a lot of my input because they know I used it a lot and I published on it. So they asked if they could do anything different with it, and I said my patients are doing extremely well, so I'm happy with it.
Q. Gynecare mesh you were using that for pelvic organ prolapse?
A. Yes. And there was a time when I was using it for individually cut sewed prolapse vaginal procedures.
Q. As you sit here today, it's no longer possible to use Gynecare for repair of pelvic organ prolapse.
Correct?
MS. GERSTEL: Object to form.

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A. I'm not doing it at all.
Q. You don't have any --
MR. DeGREEFF: Strike that.
Q. You don't have any patents on medical devices currently.
True?
A. Correct.
Q. Did you have involvement with the design of the Solyx, the Boston Scientific Solyx?
A. We may have mentioned this before. That was the one time where I was -- yes, I was in their R&D labs giving them feedback on pre-release research and development design phase and a positive and negative feedback on it, which was on their company documents, which ended up with me in a deposition not on either side, just called to be deposed on what I had written in that R&D lab.
Q. Are you familiar with the industry standards that govern medical device design?
MS. GERSTEL: Object to the

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form.
A. I'm familiar with a number of the FDA standards.
Q. What are those regulatory standards?
A. Well, there's clearances and approval processes they have to go through. There's device labeling instructions.
Q. Anything else that you can think of?
A. There's classifications that tell you how much -- whether something is based on something previous, how much data needs to come before release.
Q. Have you reviewed any Ethicon internal standards on medical device design?
A. I don't recall.
Q. Are you familiar with the stage gate system?
A. I am not.
Q. Do you know what a clinical expert report is?

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A. I think it's a -- it's a detailed statement on where the company feels a product is in terms of its research and development. I'm not certain on that.
Q. Have you reviewed any of Ethicon's clinical expert reports related to the TVT mesh sling products?
A. Since the title sounds familiar, I think I read one, and I don't recall which one it was or any of the details, but I think I -- it was in front of me at one point.
Q. As you sit here, you just don't remember anything about what it said?
A. No.
Q. True?
A. Correct.
Q. Do you know what a design history file is?
A. No, but the name kind of gives it away. But the answer to your question would be no.
Q. Have you ever reviewed the

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design history file, Ethicon's design history file, with regard to any of the TVT products?
A. I can tell you that I've read quite a number of documents that describe the evolution of the TVT products. I don't know if that's within that stated document.
So, the answer is that document by name I'm not familiar with, but I'm certainly familiar with many documents that describe the evolution of the TVT and the TVT product family.
Q. What is contained in the design history file?
A. Since I haven't seen the file, I -- I can't tell you.
Q. So, as you sit here, is it fair to say you don't know whether you've reviewed the design history file or not?
A. Correct.
Q. What employees from Ethicon were involved in the design of the TVT products?

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A. Well, the key ones were Olmstead for the TVT and De Lara for the obturator products.
Q. Have you read those depositions?
MS. GERSTEL: Object to form.
A. I have not read their depositions, no.
Q. Were those depositions given to you by defense counsel?
MS. GERSTEL: Object to form; lack of foundation.
A. I don't recall them being given to me.
Q. What is Med Scan?
A. Is that the Canada group? No? I don't know what it is.
Q. What is Provincia?
A. I don't know.
Q. Do you know what a design failure modes and effects analysis is?
A. Say it again. Design failure?
Q. Modes and effects analysis.
A. I couldn't describe it to you specifically.

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Q. Ever participated in one?
A. Well, if putting something on tension to seeing load failure and various other changes in the characteristics of the mesh when you do different things to it is part of it, then yes.
Whether I knew that I was specifically in a session that was labeled that, I don't recall that it had that name.
Q. What are the different types of failure modes and effects analysis?
A. Can't answer that.
Q. Just don't know?
A. Correct.
Q. Did you review any of the design failure modes effects analysis on the TVT mesh slings?
A. I may have, but not knowing it had that title.
Q. As you sit here, you just don't know whether you did or not?
A. Correct.
Q. Are you aware of any company

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other than Ethicon that marketed a -- that marketed mesh that was mechanical-cut?
MS. GERSTEL: Object to form.
A. Caldera's is mechanically-cut.
Q. Which product?
A. The Desara and the Desara TV Blue. There may be others, but I know that that one is.
Q. Have you ever reviewed any of Ethicon's internal operating procedures related to design?
A. I've read a lot of pages that discuss how -- how a procedure is going to be designed. And again, whether it had that title, I don't know. I've recently read a number of Ethicon documents that are discussing the process for design and feasibility and opinions as to where the product stands.
Q. So you don't know if you've reviewed the standard operating procedure or not.
True?
A. Specifically the document by

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that name, no.
Q. How long did it take Ethicon to get the TVT-O product to market?
A. I don't know. From first thought to mind to market, I don't know that answer.
Q. Is it ever a good idea to rush a product to market?
MS. GERSTEL: Object to form.
A. The product's got to get to market in a time frame that when it's felt to be efficacious and safe.
Q. Have you ever reviewed any Ethicon internal documents discussing how quickly they got the TVT-O to market?
A. No.
Q. That's not something that was ever provided to you?
A. Not that I recall.
Q. Of the opinions you --
A. I'm going to correct that.
I seem to now have refreshed my memory. I recall -- I can't recall exactly. The theme of one company

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document had to do with a need to -- a wish to get this moving along based on competition. I do remember a document that had that type of theme.
Q. Is it your understanding that Ethicon wanted to get the TVT-O to market as quickly as possible?
MS. GERSTEL: Object to form.
A. The only thing I recall was that there was -- there was wording that expressed a wish for it to be released and the timing of the release was important based on competition.
Q. So they wanted to beat the competitors to the market.
Is that what you're saying?
MS. GERSTEL: Object to form.
A. I said what I said.
Q. Well, they wouldn't want the competitors to get there first.
Right?
MS. GERSTEL: Object to form.
A. The competitors were there.
Q. Okay.

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The opinions you're giving in this litigation with regard to the TVT-O, TVT-A, TVT-Exact, have you ever published those in any peer-reviewed journal?
A. No.
Q. Have you ever been involved in any clinical trials comparing midurethral slings to any other pelvic surgery?
MS. GERSTEL: Object to form.
A. Comparative trial, no.
Q. Have you ever been involved in a randomized controlled trial involving transvaginal mesh treatment of stress urinary incontinence?
A. No.
Q. What antioxidants are added to the TVT mesh slings?
A. I do not know.
Q. What is the pore size of the Prolene mesh in the TVT products?
A. It's in the 1300 range.
Q. And it's the same for all of the sling products we're talking about, right? The TVT-O, the TVT-Abbrevo and the

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TVT-Exact?
A. Yes.
Q. Have you ever heard that pores in mesh collapse?
A. I have not.
Q. Do you agree that if mesh pores are not large enough, there can be an increased risk of infection?
A. Yes.
Q. Do you agree that if pores are not large enough, it increases the risk of erosion?
A. Potentially, secondary to the first discussion we had about infection.
Q. Do you agree that if pores are not large enough, there can be poor tissue integration that can cause mesh rejection?
A. Yes.
Q. Do you agree that you can get an infection with small pore mesh causing extrusion?
A. Yes.
Q. Do you agree that mesh with smaller pores tends to have a greater

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inflammatory response than mesh with larger pores?
MS. GERSTEL: Object to form.
A. Yes.
Q. What is the weight of the mesh in the TVT family of slings?
A. I don't have that data.
Q. Why does Ethicon call the Prolene mesh used in the TVT slings old construction mesh?
MS. GERSTEL: Object to form; lack of foundation.
A. I think terminology regarding the Ethicon family of meshes and names given to them have mistakes and confusion, and everything we're talking about in all four of these slings is type 1 wide pore mesh.
MR. DeGREEFF: I'll move to strike as non-responsive. That wasn't the question that was asked.
Q. My question was --
MR. DeGREEFF: Strike that.
Q. Do you know what I mean when I

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say old construction mesh?
MS. GERSTEL: Object to form.
A. There are different ways the meshes were put together over time. They're woven differently. They have different fiber sizes, different pore sizes. So, you know, the Prolene mesh has a long history to it.
So, the -- the way it was constructed was different in older, or let's say times past, was made differently than it is now.
Q. Well, the mesh currently used in the TVT sling products was originally developed for hernia repair.
True?
A. Yes.
Q. And it was developed for hernia repair in the gut.
Fair?
A. Yes.
Q. It was not originally developed or designed to be implanted in the vagina.
True?

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A. Originally, yes.
Q. And the mesh used in the TVT products was originally developed in 1974.
Is that true?
A. I don't have that knowledge of the date.
Q. It was a long time ago, right, when it was developed?
A. If that's the correct date, it's the number of years that it is. It's been working well for all these years.
Q. It's almost a half century ago.
Right?
A. Yeah. It's been working well for 20 years.
MS. GERSTEL: As someone who has gave birth close to that year, I take offense to that part.
MR. DeGREEFF: Trust me, I'm real close to that too.
Anybody need to take a break?
MS. GERSTEL: Sure.
(Recess taken.)
(Lind Exhibit 7, Defense Expert

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General Report of Lawrence Lind, M.D. re TVT, TVT-O, TVT-Exact and TVT-Abbrevo, June 24, 2019, was marked for identification, as of this date.)

(Lind Exhibit 8, Lawrence Lind Supplemental General Materials List in Addition to Materials Referenced in Report, was marked for identification, as of this date.)

BY MR. DeGREEFF:

Q. Sir, I'm handing you what has been marked as Deposition Exhibit 7.

Can you tell us what that is?

A. It looks like my defense expert general report for TVT, TVT-O, TVT-Exact and TVT-Abbrevo.

Q. Sir, does this report contain all of your opinions related to those products?

MS. GERSTEL: Object to form.

A. No.

Q. What isn't in your report?

A. In preparing for the deposition, I have continued to read, continued to

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pull more articles, and continued to educate myself.

Q. Sir, do you understand that in this litigation, there's a deadline for disclosing expert opinions?

A. Okay.

Q. Do you understand that deadline has passed?

A. Okay.

Q. So, what opinions did you not include in your report that you now intend to offer?

A. I just have a little more detail on some adverse events and some -- it's really the studies are in there and it's really just a little more in-depth understanding of what the studies have shown.

So, I'm not adding studies to the report. I'm just a little more familiar with the drill-down ordeal of what's within the studies.

Q. I think we're talking about two different things, and you're talking about

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the materials you relied on in support of your opinions.

Correct?

A. Correct.

Q. I'm talking about the opinions you've given in your report, the general opinions with regard to the TVT, TVT-O, the TVT-Exact and TVT-Abbrevo.

Are all of those opinions that you intend to give at trial contained in this report?

A. Well, if the legal rules are such that those are the limits, then those will have to be the limits.

I have additional thoughts, and you will guide me as to the legal process.

Q. Have you been asked by defense counsel to provide any additional opinions?

A. No.

Q. Is it your intention at trial to provide any opinions that are not contained in your report?

MS. GERSTEL: Object to form.

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A. I will follow whatever the legal guidelines are. And if I'm able to speak opinions that are not specifically in there, I will, and if I'm instructed that I'm not allowed to do it, I'll follow the instructions.

Q. Okay. Well, tell me what the additional opinions are that you have as you sit here that are not contained in your report.

MS. GERSTEL: Object to form; asked and answered.

A. There are details, there are studies which I discuss in here and I give opinions from those reports, and I have more information from those same studies which I feel is additive to my opinions.

Q. Do those studies, in any way, alter your opinions?

A. They strengthen my opinions in the same direction.

Q. So none of your opinions contained in your report are going to change?

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A. Correct.
Q. So there is no new category of opinion that you plan to provide. What you're saying is you believe that you have a better understanding now of some of the materials you've -- or, I guess, materials you've already cited in your report.
Fair?
A. I think I have information that strengthens the opinions that I give.
Q. Okay.
But nothing will alter the opinions?
A. Correct.
Q. Have you prepared any kind of a supplemental report?
A. No.
Q. So, what is it that you want to add to the report that strengthens your analysis of these materials?
MS. GERSTEL: Object to form.
A. Well, for example, you know, a report quoted often is the Schimpf meta-analysis and a high rate of leg or

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groin pain.
Q. Okay.
A. And that kind of jumped off the page at me as something that seemed out of line with a lot of the reading I have done and my personal experience. So I decided to explore that pain because I think we can all agree that if someone has an incision in the groin, it would make sense that they would have pain, some degree. Let's not say much degree. Anywhere you have an incision there's going to be pain immediately postoperatively.
For the -- for the TVT, there's pain where the trocars come out of the suprapubic region. Right after and for the groin where it comes out. And what's of important interest is how severe is the pain and how long does it last. So that number that jumps off the page which a lot of people react to as a high leg pain rate, I wanted to explore that further. So I researched and found the seven randomized control trials that go into

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making that 16.7 percent, and the data from those trials clearly indicates that clearly the preponderance, or at least 90 percent of the data shows that all of the pain goes away within a few weeks to a month. So, most of the data supporting that 16.7 is transient pain, which I think is very relevant as opposed to just the number of 16.7.
In the Ford Cochrane analysis, which is also included several times in my report, supports that leg pain tends to be transient. So that's one example of an expansion or a deeper dive into a study to say what is the 16.7 percent in the Schimpf article mean, and doing some real research, we can say what's the body of literature that goes into the real number.
Q. What other opinions do you want to add?
A. I would say I've seen an article by Teo which is quoted and it certainly sparks a lot of attention because it's a trial where they decided to stop the

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trial, feeling it would be immoral to continue the trial because they had read other articles that showed a high incidence of groin pain and that it would be -- it would be immoral to continue the trial.
I said well, let me look into it. It really seems, again, what was the data that was so alarming and what was going on in their study. And in their study, when they stopped the trial, almost all the patients who had groin pain had it resolved within a couple of weeks and there was only one patient who had chronic groin pain and it was a patient in the TVT group. So I thought it was very interesting that a study that is quoted often as how problematic that is a study had to be stopped because of the high level of groin pain reported elsewhere was in the middle of a study demonstrating extremely little groin pain and the only patient having prolonged problems was in the other group. So I think it's -- my

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main message is that if you dive into deeper into the literature, the specifics about the groin pain and how often it is severe or prolonged very strongly is compelling that the pain is transient.

Q. Okay. What else? What other opinions do you want to add?

A. I would add an opinion on the Okulu article. Okulu used Vypro and absorbable mesh compared to two others for a sling, and it's a very strongly presented as evidence that there was a better material, better alternative to the TVT type mesh for slings. And I think it's, number one, it's unreasonable to use that as evidence that a TVT could be done better with this material because the -- in taking a deeper dive it became clear to me that they don't do a procedure that looks anything like a TVT. They make a vaginal flap, a very large vaginal flap and open a big incision, which TVT does not. They cut out an island of vaginal tissue and they sew a piece of this mesh

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on top of the vaginal tissue and then they use sutures it make a hammock out of it.

So, the procedure, while in that study, I get that it showed that the absorbable mesh had some favorable characteristics compared to the non-absorbable, it was describing a procedure that someone invented that doesn't exist anywhere else in the literature. So I wanted to look a little further into, you know, what is the evidence for Vypro and the absorbable meshes because the case that there's an alternative that's more favorable is very important, I think, to our discussion in weighing the pluses and minuses here.

So I did a literature search on Vypro mesh and there are 72 articles on a Pub Med search. If you look for Vypro. And while there are a -- if you research midurethral sling, you'll get about 4,000 and when you research Vypro mesh, you'll get 72. And there are precisely two articles related to slings, and there are

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three articles, there are more articles in the Vypro Pub Med search on using it for mosquito netting than there are on using it for slings. And the remainder of this are related to non-incontinence procedures.

So, I think it's -- my main opinion that I'm adding is that the main study used that's comparative is on a procedure that doesn't resemble a TVT at all. So I think it's unfair to say that for a TVT this would be better. And that the data that's available for Vypro in the incontinence world is microscopically small compared to unprecedented data in favor of the TVT product which we're discussing. So that's an additional opinion I would give.

Q. How many of those articles related to the TVT are long-term randomized controlled trials with safety as the primary endpoint?

MS. GERSTEL: Object to form.

A. About 85.

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Q. Which long-term randomized control trials exist on the TVT?

MS. GERSTEL: Objection to form.

A. 417 had I believe 81 or 85 randomized controlled, I can't name them all, and they had about 13,000 patients.

Q. Anything else you want to add?

I just want to know so I can move to have them stricken.

MS. GERSTEL: I'm sorry?

MR. DeGREEFF: I just want to know so I can move to have them stricken.

BY MR. DeGREEFF:

Q. Doctor, were all these articles that you're talking about now available to you before you rendered your opinions in this case?

A. The Okulu article was available and is quoted in my paper, but in reviewing my expert report and preparing for this, I read through that article and I -- when I noticed that it didn't look anything like a sling and that it was new

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information for me, that it really was not a minimally invasive TVT type procedure, I said to myself gosh, if this is so different, I'm curious how much we know about this. So I looked further.

So, in reviewing my present statements, new curiosities developed, so I researched them.

Q. Yeah, that's information that was available to you though prior to issuing your opinions.

Right?

A. I guess the whole world of articles was available to me.

Q. Nothing new came out between the time you wrote your report and now.

Right?

A. Well, there have been articles that have come out, but not -- I don't think we're speaking about new articles that came out that are relevant to your discussion right now.

Q. None of the articles that you have now reviewed and wish to add opinions on were unavailable at the time you originally authored your opinions.

True?

MS. GERSTEL: Object to form.

A. That's correct.

Q. This was something that you decided to look into after having been deposed previously on the TVT.

Is that fair?

A. Well, from a time sequence, it would be after the TVT, but it wasn't from the TVT that had me do it. I was reading my report four days ago and these elements just came to mind. So this was based on things that came to mind in reading through my report preparing this week.

Q. Because those articles that you now seek to attack, those results are bad for the TVT products.

Right?

MS. GERSTEL: Object to form.

A. Which articles are bad?

Q. The ones you're talking about that you now wish to further clarify.

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Those results are adverse to the TVT products.

Right?

MS. GERSTEL: Object to form.

A. Well, I think they're -- I think they're kind of good for my argument because they -- Okulu really doesn't describe a TVT procedure. So I would consider it a strong defense that we're trying to suggest something's an alternative when it's really not doing the procedure that we're interested in.

Q. No, I understand you think you can attack those conclusions somehow.

But my question is the reason you started looking into those articles is because the results on their face are bad for the TVT products.

True?

MS. GERSTEL: Object to form.

A. The studies didn't make sense to me. The reason I looked at everything I had in my report and if something came to me that seemed curious or in question, like the 16.7 percent erosion, it just didn't seem right. So I'm a curious guy and I look into things, and I looked into it. I didn't go after it because it was negative. I went after it 'cause it didn't make sense to me.

Q. But it was negative.

Right?

A. I would say the Schimpf article was misleading.

Q. Is 16.8 erosion rate, is that an acceptable rate to you?

MS. GERSTEL: Object to form.

A. It's a rate that's misleading because that's immediately postoperative, and that's what's wrong with her data.

Q. I understand that you want to attack an author who wrote something that was actually published on the TVT products.

My question is 16.8 percent erosion, is that an acceptable erosion rate to you?

MS. GERSTEL: Erosion?

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A. Are you speaking of erosion or leg pain? Because the Schimpf --
Q. I'm sorry. Leg pain.
MR. DeGREEFF: Strike that. Let's start over.
A. So, my answer to that would be in the immediate postoperative period, I think it's a very low rate of pain where there's an incision and completely acceptable.
If that is prolonged or severe and prolonged, I would consider that unacceptable.
Q. What is an acceptable rate of chronic groin or leg pain?
A. Well, everyone would have a different cutoff because you're balancing the risks and benefits of each sling.
So, you know, I think that in the 2 to 4 percent range is acceptable, and we have to accept that in the understanding that we are decreasing bladder perforations, bowel perforations with the TVTs. So it's not just does the

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patient have leg pain. It's what we're trading.
MR. DeGREEFF: Move to strike non-responsive.
Q. My question was just simply what is an acceptable rate in your mind of chronic groin and leg pain from a TVT implant?
MS. GERSTEL: Object to the form.
A. I would say in the 2 to 3 percent.
Q. So, your report, which is Exhibit 7, is 57 pages long.
True?
A. Yes.
Q. I believe we discussed earlier --
MR. DeGREEFF: Well, strike that.
Q. Who wrote that report?
A. I did.
MS. GERSTEL: Objection. Subject to privilege.

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BY MR. DeGREEFF:
Q. Did you write the whole thing?
MS. GERSTEL: Objection. Subject to privilege under the Federal Rules of Civil Procedure.
Don't answer.
MR. DeGREEFF: I can ask that. I don't get to see drafts, but I can ask who wrote it.
MS. GERSTEL: No, you can't ask about the report writing process.
MR. DeGREEFF: I absolutely can, but that's not where I'm going with this anyway.
BY MR. DeGREEFF:
Q. Who wrote that report?
MS. GERSTEL: Objection.
Don't answer.
Subject to privilege.
BY MR. DeGREEFF:
Q. Are you going to choose to accept your counsel's request that you not answer my absolutely proper question?
A. Yes.

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MR. DeGREEFF: Moving forward, you guys won't get anything from us.
BY MR. DeGREEFF:
Q. So, did you actually physically write every word of it?
MS. GERSTEL: Objection. Same basis.
Don't answer.
A. I'm declining to answer.
Q. Are there any parts of that report that came from other people's reports?
MS. GERSTEL: Same objection.
Don't answer.
MR. DeGREEFF: I absolutely can ask that. That is 100 percent correct. If he's pulled pieces of a report from other individuals' expert reports, I have every right to know that.
MS. GERSTEL: It's all covered by --
MR. DeGREEFF: No, it's not covered by that.

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MS. GERSTEL: It is.
MR. DeGREEFF: No, it's really not.
MS. GERSTEL: It is. I'm directing him not to answer.
MR. DeGREEFF: Okay.
BY MR. DeGREEFF:
Q. Why do you think your counsel doesn't want you to tell me who wrote your report?
MS. GERSTEL: Objection.
A. I don't know whether there are legal guidelines that she feels give that that's the way it's supposed to go.
Q. Do you think if you wrote the whole thing, she'd let you answer?
MS. GERSTEL: Objection.
Don't answer that.
A. I'm declining to answer.
Q. So, it took you 25 hours to write a 57-page report.
Is that right?
A. Right.
Q. Your report also has a reliance

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list along with it. That's Exhibit 8.
Correct?
A. Right.
Q. Are you aware it was amended five days ago?
A. I remember I had come up with some articles that I had wanted to include.
Q. What was added to it?
A. I don't recall specifically at the moment.
Q. Who chose the materials that were added to it?
A. I did.
Q. All of them?
A. All of them.
Q. Who drafted the additions to the reliance list?
A. The reliance list, the typed reliance list was done by counsel.
Q. Okay.
A. The input to the reliance list this week was mine.
Q. So, this reliance list was

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supplemented because you came up with additional articles that you reviewed in preparation for your deposition.
Is that true?
MS. GERSTEL: Object to the form.
A. I think there's also one or two that were in my report which we did not have on there. So there were a couple of articles that I added and a couple that were erroneously that were not added that were already on the report.
Q. Okay.
So, is everything --
MR. DeGREEFF: Strike that.
Q. Does your supplemental reliance list, together with your report, contain everything that you reviewed in rendering your general opinions?
A. As I stated previously, I have read additional materials all week and have some other things in my head, and I do understand that you have legal reasons for why I may or may not be able to use

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those, but -- so there would be some that I reviewed that are not in there.
Q. Well, your reliance list was just supplemented five days ago.
Have you reviewed additional materials since then?
A. I have.
Q. The materials that you added to your reliance list, were you directed by counsel to look into certain issues?
MS. GERSTEL: Objection.
BY MR. DeGREEFF:
Q. Is that why you started to look into them?
MS. GERSTEL: Objection. That's will go under privilege.
Communications between experts and counsel are privileged.
MR. DeGREEFF: That's a privilege?
MS. GERSTEL: Yes, under the rules.
We can look at it right now.
MR. DeGREEFF: Not if they rely

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on it.
MS. GERSTEL: I'm sorry?
MR. DeGREEFF: Not if they rely on it. If he takes actions what you're telling him to do.
MS. GERSTEL: No, communications between expert and counsel are privileged.
MR. DeGREEFF: If you provide information that's ultimately relied on, then I'm entitled to discovery.
MS. GERSTEL: The communications are qualified under privilege except to the extent that they pertain to --
MR. DeGREEFF: I'm not asking what was said. I'm asking if he was directed to do a search.
MS. GERSTEL: That pertains to communication between me and him.
MR. DeGREEFF: You and I are going to have to disagree on that.
BY MR. DeGREEFF:
Q. In rendering the general opinions that you've got in your report,

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is everything that you relied on in giving those opinions contained in your reliance list or the report itself?
MS. GERSTEL: Object to the form.
A. Say that again.
Q. Is everything you relied on in rendering your opinions --
MR. DeGREEFF: Strike that.
Q. Are all the materials you relied on in rendering the opinions in your report contained in either your report or the supplemental reliance list?
A. No, 'cause I also depend on knowledge learned from courses, books, reading, education, clinical experience, discussion with other experts, all the time I spent in R&D labs.
So, my reliance is not just on articles. So I've had 25 years of learning that come from sources that are other than articles.
Q. Let's try this again. I think if you listen to my question, it will be

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okay.
Are all of the materials, materials, you're not a material, as far as I'm aware of, but are all of the materials you relied on in rendering the opinions in your report contained in either the supplemental reliance list or the report itself?
A. When I go to courses, there are materials, entire binders that have information.
Q. Are those on your reliance list?
A. No. I've learned them over the years.
Q. Why not?
A. Because they're in my brain. I have them.
Q. Do you understand that I have the right to understand and know about and see all of the materials you relied on in reaching your opinion?
A. I think you're totally reasonable, and I am certainly not trying to be difficult. But when you say when I

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made opinions, what I have told you I also have from opinions which is the knowledge that's in my brain from the sum total of places I've gathered information, that's part of where my opinions came from.
And if the word "materials" is something for us to focus on, in many of the places where I learned there were materials. I can't produce them. If that makes it illegal to be part of this, you know, you'll instruct me on that, and you and Diana will discuss that. But my opinions have a lot that comes from a lot of different sources of learning that don't have materials that can be put into the reliance list.
Q. I want a copy of the materials you're talking about that I haven't seen.
Do you have copies of them?
A. I have some of them. Yeah.
MR. DeGREEFF: I would like you to give your counsel all of them and then she can produce them to me.
Is that okay with you?

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THE WITNESS: I'll give you what I have, just clarifying that it won't be the full complement of every educational piece that I have. But I do have quite a few.
MR. DeGREEFF: Whatever you claim to be relying on, I want to see a copy of it. So please give it to your counsel.
MS. GERSTEL: Are you talking about every textbook he read in medical school?
MR. DeGREEFF: Right. Or at least identify it. They haven't been identified.
Well, I mean, if we're going to play this game, we're going to play this game.
MS. GERSTEL: I'm not trying to play a game.
MR. DeGREEFF: If that's the way we're going to play, if that is the game you want to play, then that is the game we're going to play.

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MS. GERSTEL: I'm not trying to play a game.
I'm just saying that he's a urogynecologist, and his opinions on urogynecology are based in part on his sum total of experience in practice and in learning as a urogynecologist.
MR. DeGREEFF: That's not the response to my question. My question is very simple.
BY MR. DeGREEFF:
Q. What materials am I going to see that you're going to talk about at trial in support of your opinions that are not included in either your reliance list, your supplemental reliance list, or your report?
A. Well, I would say if I rendered the opinions from the items that I learned outside of these materials that you have in front of them, they're going to be presented in the same way as part of my experience and knowledge as a urogynecologist.

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I'm not going to show up with binders and binders of things that you haven't had a chance to look at in the proper process.
MR. DeGREEFF: Well, if there are materials that you are going to rely on that are not on your reliance list, identify them and give them to your counsel, please.
BY MR. DeGREEFF:
Q. So, can you identify them right now for me?
MS. GERSTEL: Objection.
A. There's binders and binders of course materials I've taken every year I take one or two courses. There's the -- every year I update and I get the binder for the female pelvic medicine fellowship board certification course. It's, you know, it's like three of these binders.
And, yeah, I mean, I'll get you -- if you said you want everything that I have, I'll get you everything I have.

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BY MR. DeGREEFF:
Q. Are those things on your reliance list?
A. Well, I would say that the course, let's say the 2018 fellowship review course binder instruction and educational materials, that is not on my reliance list. There are certainly hundreds of articles from that course that are on my reliance list because a number of topics in that course are slings, efficacy and safety of slings, and, you know, all the sections that have to do with mesh and slings are in that course.
I would ask if you like, if we're going to do that, I would take out the things that have to do with constipation and, you know, things that don't have to do with mesh or slings just so that it's not like this (indicating). But if you want it all, I'll follow instructions.
Q. Right. So, this is not supposed to be a difficult question. I mean, what

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I'm trying to figure out is what I'm going to see at trial and what you're going to discuss at trial.

This is the supplemental reliance list as I know it, and this is what has been provided to us as the things you relied on. And I am not including your experience and learning and knowledge and all those things because I understand there's not a material for that.

I'm trying to figure out what materials that I'm going to look at at trial or that you could potentially be using at trial that are not included in your supplemental reliance list or your report.

A. I think we can safely say what you have in front of you are the materials, or the scientific materials that are going to come forward.

I cannot separate the literature from opinions I'm going to have based on every other source and way that I learned, that those are not going to be opinions.

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But from the standpoint of materials, I think you have what I'm going to present to the court.

The only clarification I would give there is that these articles in and of themselves have references. So those references I would consider as part of what I might reference. Meaning in the bibliography of an article, it may describe the articles that are supporting itself, and I may speak to articles that are in the bibliography that are not -- that you don't have as a full.

Q. So, it's your belief that by disclosing an article as something you relied on, that you're therefore disclosing, for example if there's a hundred citations for it, you're disclosing all of those?

A. Well, if I'm reading a Schimpf article and we're discussing Schimpf and we're discussing Schimpf which is an article I've disclosed and it is relevant to discussing the data that she discloses,

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for example the leg pain data, and it's part of my knowledge that the articles that comprise the 16.7 percent have information X, Y and Z, I consider that fair game.

If it's not legally, you'll inform me.

Q. Okay.

So, are you needing to update or supplement your reliance list? Is that what you're telling me?

MS. GERSTEL: Objection.

THE WITNESS: Am I supposed to answer that?

MS. GERSTEL: No, go ahead.

A. If I had the opportunity, given that your goal is to have everything that would be presented, I would update it.

Q. Can you update this and provide me a final reliance list that will include everything that you intend to rely on?

A. I'd be happy to do that.

And I promise that between now and any subsequent time we meet there

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won't be ten more to add. So I would be happy to, I think, come together on what this discussion's been, and if was given the opportunity to update it, I would add about ten articles and we could call that yes, you have in front of you the articles I would rely on.

Q. Okay.

A. The materials.

Q. Well, let's do that because I want a final materials list. So, I mean, that's the goal.

A. Okay.

MR. DeGREEFF: How soon can we get that?

THE WITNESS: In a few days.

MS. GERSTEL: Yeah.

MR. DeGREEFF: Okay. That's fine.

So, I'm going to mark a blank document as Exhibit 9, and then we can provide the supplemental materials list to the --

THE WITNESS: I'm making myself

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a homework note.
MR. DeGREEFF: -- to the court reporter.
Sir, for the record, can we agree that you are going to provide what is going to be a final reliance list to your counsel to be provided to me and the court reporter?
THE WITNESS: Yes.
MR. DeGREEFF: Thank you.
And we will mark that as Deposition Exhibit Number 9.
(Lind Exhibit 9, placeholder for production by the witness, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. Looking at Exhibit 8, the current version of the supplemental reliance list, that reliance list is more than a hundred pages long.
Right?
A. I believe you.
Q. Is it fair to say it includes thousands of documents and materials?

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A. Yes.
Q. Who chose the documents on that reliance list?
A. I chose the vast majority, and counsel suggested some additional.
Q. You chose the vast majority of the internal Ethicon documents that are on that reliance list?
A. No. Of the -- of the scientific literature.
I didn't choose any of the Ethicon documents.
Q. Okay.
So, of the documents on your reliance list, is it fair to say that the portion you provided input on is the medical literature section?
A. Yes.
Q. And the remainder of it was chosen by defense counsel?
A. The -- for the most part, yes.
Q. What percentage of the medical literature would you say you chose?
A. 75 percent.

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Q. Who chose the remaining 25 percent?
A. Counsel.
Q. What was the methodology you applied for choosing the medical literature that was included in the reliance list?
A. You know, I started -- I like to start on my own. I started on my own doing my Pub Med searches on the different products, then the different products plus complications, and from those choosing articles that I wanted. And when I got to areas where I felt that I was incomplete or didn't really have -- didn't seem to have authoritative understanding, I'd say do you have anything on this. Then they would provide materials.
So, you know, it was kind of a back-and-forth. It was really -- I was trying to tell my story, and when my story had gaps, I said do we have more information that I'm not finding on this.
It's hard when you try to do

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a -- you know, the limitation where requests were made, it's really just a function of how large the literature is. When you put in midurethral slings, you get 4,000 on Pub Med. So, I was very, very diligent in preparing this report, but when going through 4,000 on a midurethral sling search and, you know, several hundred when you put in a TVT-O search, a TVT-O complication search, FDA, you know, notifications list, you know, it's just -- the reality is unless I had a full-time job, I could review 10,000 documents and figure out which were relevant. So I pulled the ones which clearly looked right to me. I tried to point more towards the randomized controlled trials, that sort of thing.
So, I created a story. And when the story had areas where I didn't feel I had good literature, I said do you have articles that I don't in this area, and they -- sometimes they said yes and sometimes they said no.

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Q. Did you ever inquire as to defense counsel's methodology for selecting the literature included in the reliance list?
A. No.
Q. I think you said you spent about 40 hours reviewing the materials on the reliance list.
Is that correct?
A. Right.
Q. Fair to say you did not review every document on that 102-page supplemental reliance list?
A. I scanned the title of every article and decided which ones I wanted to look into further.
Q. Okay. So, fair to say you did not review in detail every piece of medical literature included on that supplemental reliance list?
A. That's fair to say.
Q. Did you review all of the nonmedical literature documents?
A. I'm not sure which ones you're

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referring to specifically.
Q. Okay. Well, anything that's not designated as medical literature on your report, did you review all of those documents?
MS. GERSTEL: Object to form.
A. Well, I think I stated previously that I reviewed some Ethicon internal documents and did not review others.
Q. So, it's reasonable to say that you didn't review everything on your reliance list.
Right?
MS. GERSTEL: Object to form.
A. I read the titles of each and selected the ones I thought were most pertinent.
Q. I'm not talking about just medical literature.
I'm saying you didn't review all of the documents on this 102-page reliance list in 40 hours.
Right?

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A. In detail, no.
Q. That would have been essentially impossible?
A. Thousands of hours.
Q. Right.
Would have taken thousands of hours to review all those, right?
A. In detail to really read through an article in depth.
Q. Because if you've got thousands of documents on your reliance list --
A. It's ten minutes per, minimum.
Q. Right.
So you're looking at 10,000 hours to review all those documents.
Right?
A. Correct.
Q. And you essentially did what you could in 40 hours.
Right?
MS. GERSTEL: Object to form.
A. I spent the time I felt necessary to do an excellent job on -- on the task, understanding that reading every

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item available on it provided in the world or on the reliance list was not possible.
Q. What percentage of the medical literature on your supplemental reliance list did you actually review in detail?
MS. GERSTEL: Object to form.
A. In detail, I would say 30 percent.
Q. What percentage of the total documents on the reliance list, all of them including the internal documents and everything else that's on there, did you actually review in detail?
MS. GERSTEL: Object to form.
A. I can't give you a percentage on it.
Q. How did you decide which articles to review in detail and which ones not to?
A. The quality level of the study was the primary, meta-analysis, systematic reviews or randomized control trials, and then of course I was interested on the -- I mean, I -- those are all the comparative

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trials. And then in those comparative trials, I wasn't seeing a lot of themes which I know are being proposed as problems or negative aspects of some of the products. So I looked for -- I did a -- I did a search on complications. So I went through complication articles on my search and decided to pick out ones that I should review that seemed to be at odds with the randomized controlled trials.

Q. Did you review all of the articles that were selected and provided by defense counsel?

MS. GERSTEL: Object to form.

A. I would say I reviewed every title and decided, based on the time frame I had, which ones were relevant and comprehensively reviewed a very good fraction of them, but not all of them.

Q. You have on your reliance list 17 pages -- excuse me. On your supplemental reliance list 17 pages of what are referred to as production materials. I think it's around page 75,

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if that helps.

A. In this document?

Q. Yes. In Exhibit 8.

A. Do you want to show me where that is?

Q. I'll try.

(Pause.)

Q. I'll start over.

You have on Exhibit 8, which is the supplemental reliance list that's currently available, 17 pages of what are referred to as production materials.

Do you see where I'm at?

A. Yep.

Q. And that's hundreds of documents listed on there, right?

A. Yep.

Q. What qualifies as a production material, for purposes of this reliance list?

A. I don't know what definition they give to qualify it as a production document. It's a term you're using that I'm not aware is how it's used for

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selection.

Q. Well, it's not a term I'm using. It's a term that's on the reliance list.

A. Where is that term?

Q. At the top there (indicating).

A. It says "Production Materials."

So, let's see what we got here.

This would appear to be internal documents describing various aspects of bringing product to study, to develop, to bring forward.

Q. Was today the first time you knew there was a heading for production materials on your supplemental reliance list?

MS. GERSTEL: Object to form.

A. On the heading, I had not seen the heading.

I've seen this list of documents, and I've read a good fraction of them.

Q. You didn't know there was a heading because you didn't draft it.

Right?

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MS. GERSTEL: Object to form.

A. I didn't know there was a heading because when you turn it over, it's so thick that it's covered by the stapled area.

So, in looking over this to look at each number, the heading on the page was not particularly of importance to me when I was reviewing it.

Q. I mean, you had seen the supplemental reliance list before today.

Right?

A. Yes.

Q. Was there a staple on the page then?

A. There was a clip or a staple or something.

Q. Who selected the document --

MR. DeGREEFF: Strike that. I think we already talked about this.

Q. The documents included in this production materials section were selected by defense counsel.

Correct?

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A. The internal documents were all selected by counsel.
Q. Did you review all of these --
MR. DeGREEFF: Strike that.
Q. Did you review any of these documents included in the production materials section?
A. Yes.
Q. What percentage of them?
A. 20 percent.
Q. And how did you select which documents you reviewed?
A. You know, based on what I was reading. I asked for a number of topics. I'd say, you know, tell me -- you know, I was particularly interested in discussions of laser-cut mesh. I said are there any internal documents describing concerns about the thigh and the obturator.
So, a good fraction of them were things I came upon where I felt like I wanted to know what was going on in the decision-making, and then others were offered by counsel.

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Q. Well, you didn't select any of the internal documents.
Right?
MS. GERSTEL: Objection; asked and answered.
A. I selected the topic. The information and then the internal document was provided on the several topics that I asked about.
Q. Were you given any kind of access to the document production database so that you could do your own search for documents?
A. I was given a binder of enormous numbers of company documents, and I discussed that I -- it would be impossible for me to review all of them. So it would have to be a combination of things I was interested in and things that counsel thought was most relevant for us to discuss given reasonable but pretty significant preparation.
Q. My question is, I apologize.
Were you given access to there's

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an online database where all of the documents were produced? Were you given access to that online database so you could do your own searches?
A. The online database, no.
Q. There's around 81 depositions on your reliance list. It's towards the end. It's after the production materials section.
So, that is a section on your reliance list that includes about 81 depositions.
Correct?
A. I'll trust your number.
Q. Does it look reasonable?
A. Yep.
Q. Fair to say you didn't read all of those?
A. I did not read all of those.
Q. Who chose the depositions that were included on this reliance list?
A. As stated previously, there are certain topics I asked for, which would be a smaller subset which -- which I asked

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for which generated some of these.
Now, they probably would have been on the comprehensive list they were planning to include, but I requested, let's say, 10 or 20 documents, or 10 or 20 categories of documents and they were provided, and the rest were electively provided by counsel.
Q. For example, did you review Meng Chen's depositions?
A. I don't recall.
Q. Who's Laura Angelini?
A. I don't recall.
Q. Did you read all of the Piet Hinoul depositions?
A. I didn't read all of it. I read some sections.
Q. How many of these depositions did you actually read?
A. I would say I read parts of ten.
Q. Which ten?
A. Arnaud sounds familiar, Hinoul, Charlotte Owens sounds familiar, David Robinson.

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Q. Well, David Robinson sounds familiar because I asked you about the medical director Dr. Robinson earlier.
Correct?
MS. GERSTEL: Object to form.
A. No. I recall independently that that was one of the ones that I had read.
Q. How did you select the depositions that you read?
A. It would come up in a topic. It would come up in a topic, you know, set up as what was -- what was Ethicon concerned about when they were making the obturator sling, and then some deposition testimony or internal documents were sent on that.
What other questions did I ask?
I was curious what the, you know, lead directors of the administration's opinions and thought processes were on the topics that are being raised in this litigation. So then some of the directors' transcripts were provided.
Q. So, did you review depositions

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where Ethicon employees were expressing concerns about making the TVT-O?
A. Yes.
Q. What was your understanding of the concerns they were expressing?
A. They were concerned about groin pain.
Q. Anything else they were concerned about?
A. There were concerns whether the laser-cut mesh was stiffer and if it was stiffer, if it would change the behavior and/or success or adverse reactions in the procedure.
Q. And those were -- those concerns were expressed in the -- by Ethicon employees in the depositions you read?
A. I'm mixing together in my mind the depositions versus e-mails. So this is just -- to me it's just in my head as internal documents.
Q. Okay.
Did you specifically request by name any of the depositions that are

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included in the reliance list?
A. I requested by topic 'cause I didn't know the names of the players.
I mean, looking back, I remember interacting with some of these people when I was helping to teach some of their labs and that sort of stuff, so I remember some of the names, but I didn't have any reason to select the names that I knew. There were topics that I was interested in.
Q. Then there are six pages of, quote, other materials, right after the depositions.
A. Okay.
Q. What's included in the other materials section?
MS. GERSTEL: Object to form.
A. This looks like authoritative articles or materials from authoritative entities, such as FDA, ACOG, AUA, the other quality and research and scientific administrative agencies and female pelvic medicine.
There are some studies, a lot of

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guidelines, position statements, bulletins by the authoritative societies.
Q. Who chose those materials?
MS. GERSTEL: Objection.
A. Those are mostly by me. I had put them in my report by my own discretion. And I was being followed very closely in our societies the growing, growing support of the midurethral sling based on its data, safety and efficacy profiles. So the -- it was a very strong part of my report was to -- it was a very strong part of my report to -- so, these are mostly requested by me because -- either provided by me or requested by me because they came across through my societies with a very, very strong repeated, repeated support for the case for the midurethral sling being important to preserve and important to clarify for the educational world, the patient world.
Q. You asked for Dr. Elliott's curriculum vitae?
A. No. Again, if we're going to go

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item by item, I can tell you whether I requested it.

I'm talking about the dominant fraction of these are things that I provided or requested. I did not request all of them.

Q. What percentage of them did you request?

A. The first page is about half. The second page is a quarter. The third page is a third. The page that's got Daniel Elliott, I would say none.

Q. Is it fair to say you requested less than half of the materials included in -- the documents included in the other materials section of your reliance list?

MS. GERSTEL: Objection to the form.

A. Somewhere between 30 and 50 percent.

Q. And what percentage of these materials did you actually review?

A. The ones that I requested I reviewed.

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Q. And the rest of them were put on the reliance list by defense counsel.

Is that correct?

A. Yes.

Q. For example, there are some things in the other materials that say, for example, excerpts from Budke trial transcript.

Who would have done these excerpts? Is that something you did?

A. I don't know.

Q. Who would have chosen the excerpts that were used?

A. I don't have the answer to that.

Q. Do you remember reviewing any excerpts from trial transcripts?

A. There were one or two trial transcripts which I did review. I can't tell you which ones.

Q. So, on the very last page of Exhibit 8, your supplemental reliance list, there's a number of expert reports listed.

Do you see that?

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A. Got it.

Q. Did you review all these expert reports?

A. I didn't review all of them, no.

Q. Why was it important to you to review expert reports?

A. It would educate me on the opinions of the plaintiff experts as to what they felt was most relevant and what the arguments were on the plaintiff's side.

Q. And which ones did you review?

A. When I was doing my Prolift general report, I read Garely and Elliott. I remember those names. We had one Rosenzweig report because it was associated with one of the case-specific reports. He was the case-specific expert, so I read his report when I read that. So I read three or four.

Q. So you read three or four of the maybe 30 or so that are on here?

A. Right.

Q. Did the plaintiff's expert

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reports that you read reference documents that were contrary to your opinions in this case?

A. Yes.

Q. Are those documents, are they referenced on your reliance list?

A. I have a lot of -- I was pretty good on my report about putting in, you know, negative articles that are of question.

I would say that there are negative articles in a more comprehensive list on there. They're not all in my report. But I did select articles which I felt were either I found on my own or that I was -- saw were focuses of plaintiff's reports and chose to comment on them.

Q. So the plaintiff's experts are medical literature and documents in their reports that were adverse or contrary to your opinions that were not included on your reliance list or in your report.

True?

MS. GERSTEL: Object to the

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form.
A. Some are included and some are not included. Correct.
Q. Did you review those documents or pieces of medical literature that were contrary to your opinions?
A. I read through a good fraction of them on the reports that I read.
Q. How did you get the internal documents that they referenced? Did you ask defense counsel for them?
A. When I thought it was relevant.
Q. Were those documents provided?
A. When asked for, yes.
Q. Did you pull each of the deposition citations in the plaintiffs' expert reports?
MS. GERSTEL: Objection.
A. I did not pull every one. I pulled a good fraction of them based on what the titles were and the time constraints.
So the answer is I did not pull all of them. I pulled a very good

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fraction of them.
Q. Of the deposition excerpts?
A. The depositions, I'm sorry.
The expert reports was a good fraction. The deposition excerpts, if there was a reference to an internal -- a few. A few. I can't say that was comprehensive. And the deposition reports at times were so extensive, you know, it could be a week-long deposition that sometimes the purpose of that review was not to comprehensively understand all the depositions that went on. It was to get a flavor for what kind of discussions, you know, the employees, the administrators were having related to the topic, just to get a flavor for what was going on internally there. They're extremely long and not possible to drill down on and examine comprehensively.
So I would say on the expert reports, I pulled a good fraction. On the deposition reports, a very small number.
Q. Okay.

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So, why are there so many documents on your reliance list if you're not relying on them?
MS. GERSTEL: Objection to form.
A. You know, in discussions, when we bring a topic and, you know, if I say that, you know, I've seen this internal document and I think it's relevant, I'd like to have access to the documents if I choose to review them. So then they are added.
So, you know, there are times where I'm in the discovery process and putting together the report process and I say gosh, I see that there's this internal document that talks about X. I say well, I'd like to see internal documents that discuss, you know, A, B, C. So these are added. And then the ones that I see pertinent I review and the ones that just don't make the cut based on trying to do an excellent job, but having a body of literature and internal documents that's, you know, a four-year Ph.D. thesis worth

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of true deep dive, you have to make your choices.
Q. I mean, fair to say you're obviously not relying on them if you haven't reviewed them.
Right?
MS. GERSTEL: Object to form.
A. I am not relying on articles that I haven't reviewed.
Of course I would ask the question am I permitted to review those and use them moving forward, but I guess this is really not the place for that question. I'll take that up with counsel.
Q. Yeah. I'll let you take that up with her.
I want to look at Exhibit 7, which is your report, if you don't mind.
A. Sure.
Q. On page 15 under "Complications."
Are you following me?
A. Mm-hm.
Q. There's a section where you say:

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Surgeons should also advise their patients of their own success and complication rates as well as rates that are published in the peer-reviewed literature. In our practice, the complication rates with TVT, TVT-O, TVT-Exact, and TVT-Abbrevo are infrequent, and almost without exception complications can be resolved with the patient remaining content and pain free.

Did I read that correctly?

A. Yes.

MS. GERSTEL: I'll just state it was continent, not content.

MR. DeGREEFF: Continent. That's a great point. Content is different.

BY MR. DeGREEFF:

Q. So, is it your intention to give opinions on complication rates with the TVT products in your practice?

A. The main thrust of giving opinions on complication rates comes from the enormous data.

In my practice, I have not

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collected the patients and organized them in a systematic trial where I've quantified, reviewed and seen how many come back and systematically recorded their efficacy and safety.

It is our routine practice to have them come back at three months, six months, one year and two years, and the patients come back in high frequency. Do I know it's 99 percent? Do I know it's 90 percent? I don't. I know it's a high fraction. I know that the patients are -- I know that the complication rates are low.

We have a quarterly Pelvic Surgeon Society meeting in Manhattan, and we have an agreement with all the local experts where, maintaining patients' confidentiality, we will let each other know if problems and complications have come in that we're not aware about.

So, I don't have an organized statistical study to tell you on my patients.

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I will state from my practice of seeing them regularly and insuring that they come back at those intervals, that I feel very confident that my efficacy and safety reflects that of the literature.

Q. Okay. So, I think that was a long way of saying, and maybe I'm wrong, but I think it was a long way of saying that you are not going to give opinions regarding your personal complication rates in your practice.

A. I don't think that's what I said at all.

MS. GERSTEL: Objection.

BY MR. DeGREEFF:

Q. Okay. Well, how do you track the success and complication rates in your patients? What's your systematic method?

MS. GERSTEL: Object to form.

A. The patients are not recorded in a long-term spreadsheet with data.

My way of tracking complications is making sure they come back. And there's a reminder on the electronic

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medical record, if they don't make the appointment, we call them to come back, and we get back well over 90 percent of our surgical patients at a year or two years.

So, I know and I see them at one year and two years and I know if they're having problems. So, if I have a -- my own patients and I have 90 to 95 percent of them back and I have to do one mesh exposure, I feel pretty confident that my mesh exposure rate is doing well. It is not statistically quantified, but it is, by virtue of the surveillance in our office, pretty tightly assured that I'm seeing over 90 percent of my patients back.

Q. So, this is essentially anecdotal. You don't have any spreadsheet or statistical analysis or tracking system with regard to complications with mesh patients that you can point me to or show me?

MS. GERSTEL: Object to form.

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A. I can point you to the number of cases I've done and the number of mesh erosions that have been revised. I can statistically quantify.

I can quantify, I can search for bladder injury and I can quantify that and give it to you over an N, which would be the total number. I can quantify prolonged catheterization due to voiding dysfunction.

So, these are all --

Q. Well, you need a numerator and a denominator, right?

A. Mm-hm.

Q. How do you track your patients that are lost to follow-up?

A. I would have to see if they -- on the EMR if they showed up.

Q. So, all of this you're talking about is not an analysis that you've done currently.

True?

A. Correct.

Q. You don't have any kind of

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internal registry tracking your patients to see what complications they've had over, say, a five-year period?

A. That is correct.

The preponderance of my opinion is based on the 4,000 articles on midurethral slings that are published.

Q. That's different.

You being able to opine about literature is different. I'm asking about your personal complication rates.

You have no systematic method in place at your facility for tracking complication rates and those that are lost to follow-up.

True?

MS. GERSTEL: Object to form.

A. I have a systematic method of following up to make sure that over 90 percent of my patients return and I know how they're doing. It is not recorded, collected, and it has not been made into a study with a numerator and a denominator.

Q. And you haven't tracked patients

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that are lost to follow-up, true? We don't know what their ultimate results were?

A. We call all of them back, and we get almost all of them back. We get over 90 percent of them back. That I know. And most studies of two years don't do better than 90 percent.

Q. What I'm hearing you say, and I think what we agree on, is that you have not done any kind of formal analysis and you have no tracking system in place with regard to the complications for your patients related to the TVT products.

True?

MS. GERSTEL: Object to form.

A. I would say I haven't done a formal analysis. I would say I have a tracking system to insure that I'm capturing my patients.

Q. And that tracking system is just you know how many of your patients have come back?

MS. GERSTEL: Object to form.

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A. Right. And then I know -- and I know on those patients if they have problems.

Q. What does the literature say about the average rate of patients that are lost to follow-up?

A. It's quite variable.

Q. How do you track the complication rates in your patients with regard to specific mesh products?

A. Well, I use the same mesh products most commonly.

Q. For example, what's your tracking system on the number of TVT-Os that have been implanted and whether they have had complications or not?

A. The system would be the same as I recorded -- as I responded before, is I would have the patients back and see how they're doing.

Q. Okay.

A. It's not systematic, but it's systematic that they come back.

Q. How do you track whether the

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mesh implanted in your patients is mechanical or laser cut?
MS. GERSTEL: Object to form.
A. I know the products I'm using.
Q. For example, if you use TVT-O, how do you know whether you've used a mechanical-cut or laser-cut TVT-O? How do you track that?
A. It's marked on the box.
Q. Yeah. But what's your tracking system?
A. I don't care which one it is.
Q. So there isn't one, right?
A. It's not a clinically relevant distinction for me.
Q. My question was a little different than that.
My question is there is no tracking system in place for your patients with regard to whether there's been mechanical or laser-cut mesh used.
True?
A. True.
Q. You implant Ethicon slings as

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part of your practice.
Right?
A. Yes.
Q. How many, let's start with just slings first, how many slings would you say you've implanted since you started using them?
MS. GERSTEL: Object to form.
A. It's in the 2800 to 3500 range.
Q. And we're talking about mesh slings, right?
A. Yes.
Q. When did you first begin implanting mesh slings in women?
A. Well, the TVT we first started implanting in 2000, but we had been doing some patch cut slings with suture before. So there was some modifications. But in terms of the TVT slings and the slings -- the midurethral slings that were created to be individual units and made for that purpose, around that time.
Q. That was in? I didn't catch the time. Late '90s or 2000?

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A. 2000.
Q. Which of the TVT line of slings have you implanted?
A. I have implanted all of them.
Q. So you've implanted the TVT?
A. Mm-hm.
Q. The TVT-O?
A. Mm-hm.
Q. The TVT-Abbrevo?
A. Yes.
Q. And the TVT-Exact?
A. Yes.
Q. Which of those do you currently use?
A. I use the TVT-Exact.
Q. When did you stop using the TVT?
A. I was an avid TVT user, and then I liked the idea of a smaller needle. I thought the procedure could be done with a smaller needle. So I proposed that to Ethicon. They declined that idea. So I proposed it to Boston Scientific, and they made the Advantage Fit. So when the Advantage Fit came out and was a very -- I

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thought very similar in every way with a number of very nice changes that I liked, I switched to the, staying retropubic, I switched to the Advantage Fit.
Q. Okay.
And that is a Boston Scientific product?
A. Correct. And then --
Q. And when did you switch to that from the TVT?
A. I don't know exact time. Four years later, five years later.
Q. So in 2004, 2005?
A. 2005, 2006 range.
Q. So you have not used the TVT since 2006?
A. I still use the TVT-Exact.
Q. Right.
But you haven't used the TVT, was my question?
A. Correct.
Q. And what were the advantages of the -- I guess what was better about the Advantage Fit Boston Scientific sling

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versus the Ethicon TVT?
MS. GERSTEL: Object to form.
A. I liked that it had blue sleeves over the introducer, which were easier to see in the bladder if you had a bladder perforation. The other color could get lost in the background of the bladder and be missed.
I liked that the blue tubes allowed you to twist and untwist the sling so when that it's wrapped around the urethra and there are little tiny twists to it, you could align it more perfectly.
And I liked that it was 2.3 millimeters instead of 5. That was a significantly, significantly different smaller needle.
Q. So, the smaller needle was -- what's the advantage of the smaller needle?
A. It's, you know, it passes through the tissues easier. It makes a smaller puncture in the skin. You need a smaller exit. And it lets you -- again,

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the subtleties of the case require you to move this needle, thread it between the bladder and the pubic bone, and when you fail, you get a bladder perforation. So with the smaller needle, I felt, based on the cadaver labs, that you could thread that space a little more easily and then if you do get a puncture in the bladder, you get a 2.3 millimeter puncture instead of a 5. So when you take it out, the bladder constricts at that point. And I felt that I did like that -- you know, when you did have a bladder perforation inadvertently, I liked that I went through with a needle that was half the size.
Q. And then what is the -- you said that the Advantage Fit, the Boston Scientific product, allowed for better alignment of the sling versus the TVT?
A. Well, the data and the results I was having on the TVT and the data I was aware of spoke to the fact that however that kit is made to work, it's working extremely well.

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There are times when you're getting to your final moment when you're going to decide is the sling exactly where I like it fit, how loose is it, how tight is it, how is it lying flat. And there are times where one arm doesn't seem to be perfectly parallel with the other arm. And once you've gone through with the product, if it just has a sheathe on it, you can't rotate it. You can't straighten those out.
So this is just a visual, a visual thing that aesthetically looks like if you want a sling to lay around, you'd like it to look like that rather than slightly turned. So those tubes, because they had some memory to them, allowed you to make those turns and adjustment and have the mesh visually appear to be flatter. When you pulled it through the canals they seemed a little bit askew.
Q. These are the tubes on the Advantage Fit?
A. Yes.

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Q. Why is it important for the tensioning to be correct on the sling?
A. Well, because every sling -- every single sling ends up too loose, just right, or too tight. So you got to use the teaching on how to do the procedure and to leave it truly tension free to try to get the results that the original procedure was producing.
Q. What happens if there's too much tension on a sling?
A. In the mild case, the patient would have a little difficulty voiding, need a catheter for a couple of days. In a moderate case, she'll need it for a week. And in a more significant case, she's not able to regain normal voiding function and you have to release the sling.
Q. And by release it, you mean removal or revision surgery?
A. Yes. There are some people who describe in the short-term as putting a obturator in the urethra and pulling

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downward to loosen it. And there's little data on that and I don't favor that. But yes, I would generally be talking about revision surgery if they had retention.

Q. And these things you liked about the Advantage Fit by Boston Scientific were things that you had brought to Ethicon and they declined to do?

A. Only the narrow needle was my idea. The things having to do with the tube were theirs.

Q. And the needle was important for reducing the extent of surgical complications.

Is that kind of the deal?

A. Yeah.

Q. Which is a patient safety issue?

A. Yes.

Q. So, when did you start implanting the TVT-O?

A. I started implanting about a year after it was released. 2005, 2006.

Q. Did you implant -- I mean, how many TVT-Os would you say you've

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implanted?

A. About 150 to 200.

Q. At some point, did you stop using the TVT-O?

A. I did.

Q. When was that?

A. We -- we were approached with a problem with cost issues where we had seven or eight doctors and each one wanting three different slings. So the hospital had an inventory which they felt was impossible, and they said we need you to get together with your data, individual preferences and options for slings and come up with what you want.

And the Caldera, I had seen the Caldera product line and it was very, very favorable in our review. It was favorable because of cost. It was favorable because it comes with one piece of mesh that can affix to reusable instruments that let you do every sling, inside-out sling, outside-in sling, top-down retropubic, bottom-up retropubic, all. At any time in

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the case you could switch. So it was very flexible in terms of what you could use it for. It was quite a bit of a cost and it met many doctors' needs all at once. So we trimmed down our product line and gave up the TVT-O.

Q. And when was that?

A. I can't tell you exactly. It was -- I don't know exactly.

Q. Last five years? Last ten years?

A. I would say five years ago to six years ago.

Q. Did you compare the Caldera to the -- the Caldera is a sling.

Correct?

A. Yes.

Q. And was it the Desara that you chose?

A. Yes.

Q. And is it -- did you, before choosing it and eliminating the TVT-O at your hospital, did you look into the safety and efficacy comparison at all?

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A. We used it in a lab about 20 times and looked at it in the hand and looked at biochemical properties and determined it was not the same, but very similar.

At that point when Caldera had come out, we really had data from most of the sling products that they were relatively equivalent in efficacy and safety.

In answer to your question, they did not have significant data on it, no.

Q. When did you start using the TVT-Abbrevo?

A. You know, when it came out, the concept was appealing and I would alternate between my slings, giving it a try. I used it probably 30 or 40 times. I thought it was a very nice sling. I thought I was -- with my other obturator slings, I wasn't having groin pain.

So, I kind of thought to myself we have some data on Abbrevo. It's clearly not going through all the same

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tissues. So we have the potential advantage that it's not going all the way through the muscles, so maybe there will be less leg groin pain, but how well is it anchored.

We did have some studies to show relevant equivalency to full-length obturator slings, but I felt that from doing obturator slings and not having groin pain other than from the first week or two, I felt more secure having a full-length sling. So I just decided mostly to stay with that.

I do occasionally order it just for the sake of fellow teaching to show the variety of the sling.

Q. The TVT-Abbrevo is not a full-length sling.

Correct?

MS. GERSTEL: Object to the form.

A. Correct.

Q. How long is the TVT-Abbrevo?

A. I don't know the exact length.

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I'd guess at 12 or 15, but I don't know the exact length.

Q. I think your report does. I think it's 12 centimeters, according to your report.

A. Yeah, that's what I recall.

Q. Does that sound accurate?

A. Sounds about right.

Q. What is the length of a full-length TVT sling?

A. I think it's in the 23 to 25. Somewhere in that range.

Q. And what was the length of the TVT-S, the mini sling?

MS. GERSTEL: Objection.

A. That, I don't know. That was shorter. I didn't use many of those.

Q. Fair to say that the TVT-Abbrevo is closer in length to the TVT-S mini sling than it is to the full-length TVTs?

MS. GERSTEL: Objection.

A. I'd have to put the numbers on paper, but I don't think the size comparison is the relevant issue.

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Q. Yeah, that wasn't my question.

My question is is it fair to say that the TVT-Abbrevo is closer in length to the TVT-S mini sling than it is to the TVT full-length slings?

MS. GERSTEL: Objection.

A. I would actually say no, I disagree with that because let me -- I will say out of the box the answer is yes, but when you talk about the full-length TVT is meant to be very, very long so that if you have an obese patient, the mesh can emerge from the abdominal wall which has very variable size. So when you talk about how much is cut off and how much is left in the body, I would suggest that the length of the mini TVT or the TVT Secure, which is going to the undersurface of the pubic bone where it's at a junction with the obturator muscle, and the TVT-Abbrevo is going to perforate the muscle, those are, you know, a centimeter apart.

In terms of the part that's left in the patient, I think they're probably

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pretty similar.

Q. When did you start using the Abbrevo?

A. 2006.

Q. When did you stop?

A. 2010.

These are approximates.

Q. Yeah, sure.

You said you were more comfortable using a full-length sling.

Why is that?

A. To be clear, my vast preponderance of slings are retropubic, and the reason for that is I started using it in 2000. I had 600, 800 cases done before any obturator sling came out. I was thrilled with my results. I went from doing a Burch with a full incision with an open laparotomy to the TVT sling, which was 15 minutes. I was not hitting the bladder 'cause my skills are good. I was getting extremely low complication rates. So I had something that the patients were -- had very fast recovery. Took me

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15 minutes to do. And when the obturator came out, I said to myself that's pretty cool. That's very interesting. I'm going to select my patients to do that when I have anatomy that gives me a reason not to do the one I like because the one I like it would be hard for me in my personal experience to improve upon it because 15 minutes, loving my results and almost complication free, no reason to change.

So, I used my -- mostly did my obturator slings when someone had a hernia, had a previous hernia repair, they had a previous retropubic surgery like a Burch or a Marshall-Marchetti, abdominal wall surgery with mesh, reasons to stay away from the target zone for the retropubic regular TVT.

Q. Again, I appreciate that. My question was different though.

My question was your testimony earlier was that you felt more comfortable with a full-length sling.

Why would you prefer a

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full-length sling over a shorter sling?

MS. GERSTEL: Object to form.

A. Well, in the case of the retropubic -- are we talking obturator or retropubic or just across the board?

Do you want to break it down?

Q. I'm talking about the TVT-Abbrevo.

A. The Abbrevo.

So, I wasn't having any significant groin pain past the immediate perioperative period with the full-length sling. So, since I wasn't having problems with the potential problem with the full-length sling, the only reason to go to Abbrevo is that you're concerned with groin pain or you're having groin pain and you want to see if you can reduce that by having a thread going through instead of a piece of mesh.

So, since I wasn't having the pain that would lead you to Abbrevo, I said to myself I have some studies, but they're very early studies and few about

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the Abbrevo. Does it hold as well. So I said the Abbrevo is not going through all the anchoring tissues. So, since I'm not having groin problems, I'll stay with the full-length sling because I don't feel I need to move away from a groin pain problem because I wasn't having it.

Q. Okay.

Yet the TVT-Abbrevo was brought up by Ethicon in response -- it was supposed to reduce the groin pain associated with the TVT-O and other obturator devices.

True?

A. Yes.

THE WITNESS: I'm going to take a break just for the bathroom, if I may.

(Recess taken.)

BY MR. DeGREEFF:

Q. When did you begin using the TVT-Exact?

A. When it came out, I was using Caldera and I was using the Advantage Fit.

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So I mixed it in for teaching purposes. I liked the idea that I was getting the Ethicon product back because, you know, it owned the data. So now we kind of took the things that Advantage Fit had kind of changed that I liked. I really liked the slimmer needle for my, again, teaching situation, residents and fellows. So now I had the original with a slimmer needle and with tubes. So that we kind of brought back the two things. So I started using that a bit more frequently.

Q. And you started that when?

A. Pretty soon after it came out. I usually -- most things I'm the kind of person that says let my other expert buddies get 50, 70 cases done and make sure everybody's having a nice time with it and then I join in.

Q. And how many have you put in at this point, do you think?

A. Three hundred.

Q. And how many, I never asked you, how many of the original TVT did you put

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in?
A. That was before there was a competitor. So like ten to -- like 500 to 600.
Q. The TVT and the TVT-Exact are placed by retropubic approach.
Correct?
A. Yes.
Q. And the TVT-O and the TVT-A were transobturator approach?
A. Yes.
Q. I think we may have talked about this already, but it's all a blur because it's been four hours.
The transobturator approach has a higher re-operation rate.
Correct?
A. Yes.
Q. It's understood typically that the slings placed using the transobturator approach are less durable than those using the retropubic.
True?
MS. GERSTEL: Object to the

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form.
A. The data's mixed on that. There are RCTUs that show them to have equal efficacy at two and five years, and there are RCTs that show some better durability of the TVT-O over time. That's as I recall the literature.
Q. Of the greater durability of the retropubic over time?
A. Right. But that's not the dominance of the data. The preponderance of the data shows relatively equivalent rates, and Ford and Cochrane's analysis shows that.
Q. So the data shows that the devices placed via the retropubic approach are equally or more durable than those placed via the transobturator.
Correct?
A. Yes.
Q. Are you aware of studies finding the rate of re-operation twice as high with the transobturator approach?
MS. GERSTEL: Objection; asked

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and answered.
A. I am aware that there are studies showing that. I don't believe that that is the collective data of all the meta-analysis, but there are studies that do show that.
Q. Okay.
When you were implanting the TVT-O and the TVT-Abbrevo, did you advise your patients that there was a potential increased risk with the obturator approach?
MS. GERSTEL: Object to form.
A. I advised them of both techniques, and I advised them of advantages and disadvantages of both. So I did include the proposed advantages of the TVT-O, and I did tell them the proposed adverse reactions associated with each, because they have a little different profile, each of the slings.
Q. What were the differences in potential adverse events between the TVT and the TVT-O?

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A. So, the TVT has a higher incidence of organ injury, bladder injury and voiding dysfunction.
The TVT-O has a higher incidence of vaginal sulcus perforation, sometimes called an angle needle introduction, groin pain, I would usually describe to them as typically transient and in rare cases prolonged, and with those being the major differences.
Q. Was the major reason for those differences the retropubic versus the transobturator approach for placement?
A. It was the anatomic pathway?
Q. Would the problems associated -- that you would have told your --
MR. DeGREEFF: Strike that.
Q. Would the differences from an adverse event standpoint between the TVT and the TVT-Abbrevo have been similar to the ones we just discussed?
A. I think they would be similar, but I think the data bears out, and it makes sense, that you would have a

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somewhat lesser chance of having groin pain.
Q. Do you consent the patients to the implant procedure prior to implanting mesh slings?
MS. GERSTEL: Object to form.
A. Hundred percent.
MR. DeGREEFF: What's the objection?
MS. GERSTEL: I'm sorry?
MR. DeGREEFF: What's the objection?
MS. GERSTEL: You said do you consent patient to the implant procedure. I'm a little confused by exactly what you mean by that.
But my objection's on the record.
BY MR. DeGREEFF:
Q. As part of your consent process, you explain to them the risks and complications that Ethicon mesh slings can cause?
A. Yes.

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Q. What risks and complications do you tell them are associated with the TVT-O?
A. The TVT-O, I tell them you can have bleeding. You can have pain. You can have dyspareunia. You can have groin pain that is usually transient, but can, in some cases, be longer standing and require revision. You could require revision for a failure of the procedure, for the procedure being too tight. I inform them of the chance of exposure-slash-erosion. I tell them there's a chance of voiding dysfunction. There's a chance of puncture of the urethra or the bladder.
Q. Those are all complications that could be caused by the TVT-O mesh sling.
True?
A. Yes.
Q. When you advise them about pain, do you advise them about the potential for chronic pain?
A. I tell them there's a potential,

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but it's rare.
Q. And what about dyspareunia, do you advise them of the potential for chronic and ongoing dyspareunia?
A. I do.
Q. Exposure and erosion, what is exposure and erosion?
A. Well, you could probably ask ten experts and get ten different answers, but I would put it this way.
Exposure, literally the definition of the word means you can see the mesh. So, let's say the wound is open somewhere. How it got opened we're not talking about, but you can see the mesh.
In erosion you're also seeing mesh. And I would say the distinction I make when you try to think of pathophysiology is that when you do a vaginal procedure, you make a single incision through a very thin tissue. As opposed to the belly where you go through three or four layers. So it is a dependent position, and you cannot put a

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wound dressing on it to support it like you do elsewhere. So it is vulnerable to fluid collecting.
I'll try to speed this up.
A wound can open and if a wound opens and you have a wound failure because your enclosure wasn't good or you had some fluid collection, the wound opens. Then you'll have an exposure. To me that usually looks like the -- the wound looks innocent. It doesn't show signs of inflammation, of an active process. It just looks like a wound that's separated.
When I think of erosion, I think of a more active process. The body didn't like the material that was in there or it got infected. There's a reaction going on and the tissue looks much different. It looks inflamed. It looks like it's pushing it out as opposed to the walls of the wounds that opened and the exposure that's just kind of dangling there free. And in an erosion everything there seems to be more of an active process.

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So, I don't think there's a strict scientific or medical definition of it. I try to look at it this way, and that's from the vaginal exposure.

In terms of an erosion into the urethra or into the bladder, you know, those are even tougher because, you know, in the case I described to you, you can just have a wound that opens. So hypothetically, on an erosion to an internal organ, the mesh is moving from one place to another. It was my strong belief that most erosions to internal organs were there when the patient left the operating room.

Q. Mesh can lead to mesh erosion. True?

MS. GERSTEL: Object to form.

A. I would say that I've never seen a mesh placed in the right place lead to erosion if erosion is an active process.

Q. You can't have mesh erosion or mesh exposure without mesh. Fair?

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A. Right. Correct.

Q. And transvaginal mesh can cause foreign body reaction, right? Like we talked about earlier.

A. Yes.

Q. And that can cause inflammation?

A. Yes, it can.

Q. And that can cause chronic pain?

A. It can.

Q. Are the complications that you tell your patients are associated or caused by the TVT-Abbrevo similar to what you advise them on the TVT-O?

A. I explain to them the difference. I explain that they have a light -- a likelihood, but not -- of less chance of having groin pain, but not no chance.

Q. But other than groin pain, would the other complications that we talked about being caused by the TVT-O remain the same for the TVT-Abbrevo?

A. Yes.

Q. I'm just trying to make it so you don't have to go through them all again.

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With regard to the TVT-Exact, how would the -- when you -- the complications that you tell your patients are caused by the TVT-Exact, how would that be different than the TVT-O?

A. I tell them they're very similar. I say this is an evolution of a device and this one is a little bit slimmer. Other than it being slimmer, it's the exact same procedure. I feel in my hands that it lets me go through the spaces a little more easier, and if there is an inadvertent puncture of the bladder, which does happen in a few percentage cases, I like the fact that the hole is smaller and it heals spontaneously.

Q. Other than those differences, would the complications caused by the TVT-Exact that you consent your patients to be the same as what we discussed with the TVT-O?

A. Yes.

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Q. And the things we've discussed, these complications we've discussed with regard to that you consent your patients on for the TVT products, those are things that are not good for the patients. Right?

MS. GERSTEL: Object to form.

A. Well, when I'm consenting them and telling them a list of adverse reactions, by definition adverse reactions are not good for the patients, but they're a known risk and they're part of risk-benefits of trying to get the benefit of being dry.

Q. As part of your practice, you treat women suffering from complications caused by mesh slings. Right?

A. I do.

Q. In fact, you're at a tertiary care hospital. Right?

A. Yes.

Q. And you're actually referred

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mesh complications from other places in the State of New York.
Right?
A. I am.
Q. Are there any other states other than New York that you receive referrals of women suffering from mesh complications from?
A. 1996 I -- well, before the mesh -- you still had other meshes then, but, you know, '96 to 2005 I was one of, like, five people in the area. So I had people from multiple, multiple states. So now we've got good trained people in a lot of places, so they come from far less often, but I still will get people from New Jersey, Pennsylvania, Upstate New York.
Q. Okay.
There are doctors in referral centers like yours for women suffering from mesh complications in states all over the United States.
Correct?

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A. There are many now, yes.
Q. And how many referrals a year do you receive from women suffering from mesh complications?
A. It's decreased quite a bit over the last five years. I think over the last five years the people knowing how to do them right are doing them more often and people whose techniques perhaps weren't as good are doing them less often.
So I would say right now I get between five and ten a year.
Q. Do you know what mesh products have been pulled off the market in the last five years?
MS. GERSTEL: Object to form.
A. I might not be able to name them all, but I know a lot of them.
Q. Do you think that has anything to do with the decrease in the number of women you're seeing with mesh complications?
A. No.
Pardon me. Referring to

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decrease you're referring to slings or vaginal mesh or both?
Q. I'm referring, in that question, I was referring to transvaginal mesh, period.
A. So, then no. I would correct my answer. I'm sorry.
Yes, I think with the removal and direction not to use those products and taken off, it's decreased the access.
And I certainly wish they'd do that to the machine guns that have been going off in the last couple of weeks.
Q. What complications caused by mesh slings do you treat in your practice?
A. Retention, obstruction, exposure-slash-erosion, dyspareunia. I'm not seeing a lot of groin pain. Occasionally urethral erosion.
Q. How about chronic UTI?
A. The chronic UTI is a tough one when you have to try to attribute it to mesh when you see patients that have slings in place that have chronic UTI.

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So, if you have something related to the mesh that explains it, so they're retaining urine and they're not emptying and the natural flow process and cleansing process isn't working, you know, you say releasing this would probably help.
It's sometimes hard when you get a patient who has chronic UTIs and there's no obstruction. They empty well. The cystoscopy's clear. There's no exposure. They're not behaving inflamed or infected. So it's hard. Sometimes we have to make decisions that we don't see something that would make sense that it would be from the sling and you have to judge that.
So when there's an obstruction and retention, makes sense. Obviously when there's a piece of mesh in the bladder, makes sense.
We do have situations where patient comes in and says I have infections, is this from my mesh. And we do our assessment and I don't find

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something that logically attributes to it, and you have to decide what to do with it.
Q. Have you seen pieces of mesh in the bladder?
A. Yes.
Q. How about inflammation, you treat women suffering from inflammation from mesh?
A. Whether the patients come with, like I said, exposure, erosion, most of them are quiet exposure. They notice it because either they felt it when they were touching themselves or the partner felt it. Most of the time mesh exposure is found innocently. They didn't know it was there.
When you talk about inflammation, I would say in a small fraction of the exposure-slash-erosions they come in and it seems hotter. That's the one I would say where I was speaking before I'd say this seems to be more of a this one's being extruded because it seems like an active process and they're

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sensitive and inflamed. But that's a minority.
Q. But I think the answer is yes, you do treat women that have inflammation caused by mesh?
A. Yes.
Q. Do you perform surgery to treat transvaginal mesh complications?
A. Yes.
Q. How about treatment of transvaginal mesh complications caused by mesh slings?
MS. GERSTEL: Object to form.
A. Yes.
Q. What kind of surgeries do you perform?
A. If they're too tight, I loosen them. If they're in the bladder, we take it out of the bladder and repair the bladder. If it's in the sulcus and it's uncomfortable with vaginal pain, we have to refresh the sulcus and sometimes the -- you might be through into the vagina and sometimes it might be behind the vagina.

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So not a true exposure, but as uncomfortable. So sometimes we have to release the side band. I've had to do one groin exploration.
Q. What do you mean by "groin exploration"?
A. An obturator sling who had discomfort by the groin that it was persistent.
Q. Have you done removals or revisions related to the TVT mesh products?
A. The retropubic?
Q. Any of the products in the line.
A. Yes.
Q. How many?
A. 20 to 30.
Q. Mesh slings, generally speaking, how many removal or revision surgeries do you think you've done?
A. In total?
Q. Yes.
A. I haven't quantified it. It's five to ten a year now. It was ten a year

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earlier.
I would say hundred to 150.
Q. So, you currently do five to ten mesh sling removals per year?
A. Some kind of revision.
Q. What are typically the indications for revision of the TVT mesh sling products?
A. The number one indication truly is that their doctor saw it and told them that your mesh is exposed, you should have it taken out. So they come asymptomatic and worried about their mesh. So we have a chat about if you're okay and you're fine and you're not having any symptoms, you don't have to do anything about it. Half of those patients will say let's get it out, I don't want it there. And half will say hey, if I'm feeling great, let's leave it.
So, the most common indication is referred from a physician for something they didn't know about 'cause they -- the physician -- their primary care OB-GYN saw

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an exposure.
Q. So the most common is they're referred for mesh exposure?
A. Yeah.
Q. And what other indications lead to removal of the TVT mesh slings?
A. They have pain or dyspareunia or the partner felt something.
Q. And you've revised TVT mesh slings based on all of those indications. True?
A. I wouldn't be able to say for every single one of those indications there was a TVT product. That's -- that's too exact to say that for every one of those it was a TVT.
You know, they come and sometimes we could have the op report; sometimes we don't. Sometimes we know exactly which sling it was; sometimes we don't. We do our best to get operative reports. Sometimes we get them; sometimes we can't. Sometimes they've had stuff done in another country.

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Q. These would all be examples of reasons you've revised mesh slings. True?
A. Yes.
Q. What percentage of your practice is related to treating transvaginal mesh complications?
MS. GERSTEL: Object to the form.
Is that all transvaginal mesh?
MR. DeGREEFF: Right.
MS. GERSTEL: I'll just object to the extent it's outside the scope of this deposition.
A. I'd see about 200 a month. I'll see one every other month. One out of 300 to 400. It's pretty low.
Q. That's related to transvaginal mesh complications generally speaking?
A. Yeah.
Q. Have you ever treated a patient with mesh that --
MR. DeGREEFF: Strike that.
Q. Have you ever -- well, yeah.

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Have you ever seen a patient with mesh that is roped, curled, frayed, deformed, folded or wrinkled?
A. I've never witnessed those things.
Q. Do you agree that those things increase the risk of pain for a woman?
A. I don't know that those have been assessed in the patient in a study. These all seem to be things of excised mesh and I think the mesh sits differently in the body when it's excised. So I don't see it roped and curled and all of that. It takes the shape of the tissue it's in.
Q. So you've never seen or never treated a patient that had mesh that was deformed?
A. How do you define "deformed"?
Q. How do you define "deformed"? You're the doctor.
A. I will say on some prolapse cases, if you have a piece of mesh that's attached and the attachment released, so if the procedure fails, then the -- then

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the mesh will come upon itself and have some folding. I've seen folding on a mesh failure because the attachment points have released, but I don't see curling and roping and what those things are that are described. I don't see them.
Q. You've never seen any of those with regard to mesh slings?
A. I've seen mesh folded on itself when there was a prolapse failure. So the mesh that was attached got released and it came back upon itself and folded.
Q. I'm talking about mesh slings now.
You're never seen a mesh sling that was roped or curled or frayed or anything?
A. I don't know if you consider roping. When a sling is tight and you're going to release it, when you see that patient and it's tight and you go and look at -- and you release it, it looks a little narrower. I don't know if that's roping or curling. It does look a little

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narrower when it -- when it -- when the tissue contracts and the sling contracts with it for whatever reason for that patient and the small fraction that end up too tight and you have to go back, it looks a little slimmer.

Q. Well, that's contraction of the mesh.

Correct?

A. I don't know that it's contracture. The mesh looks smaller.

Q. So you're saying when it contracts and it gets under greater tension, it looks thinner?

A. I don't know if it's an inflammatory response that encases it. I don't know if it's a tissue response. I don't think we have studied that. And to know what I'm referring to what's happening at that point. It just looks a little slimmer.

Q. But you've seen mesh slings that have changed shape, that look slimmer.

True?

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A. When I take out patients that have obstructions, they look a little slimmer under the urethra.

Q. In your experience removing the TVT products, were you able to remove all of the mesh?

A. There are times where you decide that you need to remove all the mesh and times when you decide you don't need to.

When I decide a patient needs it to be removed, I have removed all of it.

Q. You agree that physicians are often unable to remove all the mesh?

A. It depends on their training. The patient having a revision is best off with someone with extensive experience in handling this.

Q. Well, there are times when it's just not -- when you're just not able to remove all of the mesh.

True?

A. I have never had a case where I couldn't remove the sling in totality when I needed to.

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Q. It is challenging to remove all of the mesh from a woman who's suffering complications.

Is that a true statement?

A. There's some dissections that are more difficult than others, but I don't consider it to be an extremely difficult procedure.

Q. For example, you know that there's -- with the TVT-O product, you can never safely removal all of the mesh from inside a woman once it's implanted.

Right?

A. I agree.

Q. Okay.

A. The problem you're having, and to clarify that disagreement, is that there are surgeons who are taking out mesh and they really only have the training to take it out from the middle of the vagina as far out laterally as they can reach, and then there are surgeons who know how to get behind the pubic bone and get what's behind the pubic bone and get

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what's wrapping around the descending pubic ramus.

I've had obturators that were taken out in totality several times.

Q. You had some that you couldn't take out in totality?

A. No.

Q. Okay.

A. Now, microscopically, do I know that there's nothing there, it seemed to us that there was nothing more there. A continuous band of ribbon.

Q. Doctor, have you ever been employed by a medical device company?

A. As a consultant, not on a payroll.

Q. I understand the consultant.

I'm saying have you ever been an actual employee of a medical device company?

A. No.

Q. You have been a consultant for a medical device company.

Correct?

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A. Yes.
Q. Which ones?
A. The Laurus Corporation, Boston Scientific, Ethicon, Caldera.
Q. What about Asera?
A. No.
Q. You've never been a consultant for Asera?
A. When AMS was around, I had a couple, very few. So very briefly you could add it to the list, American Medical Systems.
Asera, no.
Q. Okay.
A. Do they go by another name?
Q. Not that I know of.
A. No.
Q. When did you start working for Caldera? I guess start consulting for Caldera?
A. About five, six years ago.
Q. So 2013, 2014? Something like that?
A. About that.

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Q. What did Caldera have you doing?
A. Well, as I said, we got involved in them first in a non -- I got involved with them first in a non-consulting way. I liked their set of mesh kits, their ability to do everything in one kit, less expense and flexibility of the kit. So they're a small company. And I said, you know, I like to do design innovation. Can we take a look at your products and talk about what can be improved.
So, if you take a look -- not that you would take a look to do their history, you'll see that Caldera now has a blue sheathe covered narrow sling, which was my original wish back with Gynecare and Boston Scientific.
We -- they wanted to be also involved in the abdominal sacral suspension market. We talked about the weight and veracity of their mesh and how it handled and how it might be marked and colored and helped them develop the mesh for sacral suspension.

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We talked about what's unique about their trocar delivery flexibility and what could be added to that to continue to improve the flexibility options for patients. For instance, took the obturator trocars and said, you know, every woman's not the same size. Let's make different sizes. So there are some measurements we can use different sizes.
So we've done a lot of different things that are tweaking things. Some have been adopted. Some are in the thought process. Some have been rejected.
Q. So, were you essentially -- were you helping them with product design, or were you helping them with research and development?
I mean, do you know how were you classified there?
A. It really is research and development. It's trying to decide on new products and how to alter products to improve them.
Q. Were you working on sling

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products?
A. Sling and mesh products for sacral suspension.
Q. And what were your -- what did you tell them about the weight of their mesh? You mentioned that as one of the things you were talking to them about.
A. I said there seems to be, you know, across the slings -- across the very popular area of abdominal sacral suspensions is a huge broad area of stuff that's really, really lithe, that I thought was too lithe to things that were really stiff, and I thought their mesh handled well and was within the realm of acceptable weight and handling and I liked it.
MS. GERSTEL: Could I just note for the record I don't know the extent to which any work that Dr. Lind did with any company is confidential. He's obviously taken on oath to tell the truth. I don't think I'm in a position to direct him not to answer

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any of those questions, but I also don't know if we might need to seek that some of this testimony be kept confidential.

I just want to say that for the record. I'm just not sure. I just want to state for the record I might need to explore that after this deposition. I'm not going to direct him not to answer the question.

MR. DeGREEFF: I mean, if you want to move to have it sealed or something, we may agree to that. I just don't know what it is. If there's some reason for that, then yeah, we can talk about it.

MS. GERSTEL: All right.

BY MR. DeGREEFF:

Q. So, what were the improvements that you suggested to slings?

A. For Caldera?

Q. Yeah. I mean, you told me that you were looking at ways to improve, kind of, the slings that were currently on the

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market.

What were some of your suggested improvements?

A. Well, the ones that are already out there are ideas that I am holding confidential. They haven't been put out there yet.

They adopted some things that were already there with other slings which was the narrow trocar and a colored sheathe that could be identified. So those aren't hidden or protected ideas. They're -- there are some ideas on the table about how to, one, make the sling passage more comfortable in the postoperative setting for pain; and two, to identify an inadvertent pass in the bladder that you might miss.

Q. Anything about the mesh material itself?

A. No.

Q. Are you still consulting for Caldera?

A. Yes.

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Q. So, basically 2013 to 2014 to present you've been consulting for Caldera?

A. Yes.

Q. How much are you being paid by Caldera? Is there some sort of a yearly consulting rate or something like that?

A. It's an hourly rate. Just based on à la carte services given.

Q. What is your hourly rate with them?

A. Four hundred an hour.

Q. How many hours a year since 2013 or 2014 do you think you've spent working with Caldera?

A. It varies. You know, if we're in the middle of a product that they've bought into, it could be 50 hours in a year.

Last year was only seven or eight hours. So it varies quite a bit.

Q. Are you aware of multiple years working for them where you made more than $20,000?

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A. Maybe two.

Q. How far do you think you've been paid by Caldera since you started working for them?

A. Fifty. 50,000.

Q. You use Caldera slings. Right?

A. I do.

Q. Is the Desara your sling of choice?

MS. GERSTEL: Object to form.

A. It's the one I use most commonly.

Q. What percentage of the time do you use the Desara?

A. 75 percent.

Q. What percentage of the time do you use one of the Ethicon TVT slings?

A. Ten percent.

Q. And what are the other products you use? The other sling products you use?

A. I use Boston Scientific, Caldera and the Exact.

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Q. So, you would use the BSC you use, is that the Advantage Fit?
A. Yes.
Q. What are the differences between the Desara and the TVT slings?
A. Well, the meshes are different. The shape of the trocars are similar. The pathways are similar. The Caldera is reusable trocars and comes with the ability to change direction, size and shape of your trocars. The Caldera for the obturator has inside-out and outside-in.
Those are the major -- those are the differences I can think of.
Q. How are the meshes different between the TVT slings and the Caldera?
A. Well, the present mesh I like to use for Ethicon is the TVT-Exact. So it's laser-cut and the Caldera is mechanically-cut.
Q. Any other differences?
A. I'm sure there's a chart I've seen where their porosity and pore size

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have some other differences. So they do, you know, on a -- on a chart of mechanical properties they differ.
Q. The Desara is larger pore mesh than the TVT-Exact.
True?
A. I think we had that one before, and I thought we had -- I thought that was the other way around, but I could be mistaken.
Q. Is the Desara more resistant to deformation than the TVT sling products?
A. I'm not aware of that being studied officially or by myself. I don't notice a difference clinically.
Q. So you're not aware of literature that says it is?
A. I don't know if one of the mechanical studies that pulled on each thing described it in a certain way.
I do remember in that same article that has the chart that says the pore sizes and the weight, I think it also discussed what happened to them under

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stress and it probably shows different properties. I don't remember what it shows.
It behaves the same in the patient for me.
Q. Are you aware that Caldera makes the claim that their product, their TVT product is -- that the Desara is more resistant to deformation than the TVT products?
A. I wasn't aware of that.
Q. So you don't have any idea what that claim is based on?
A. I do not.
Q. Do you have any reason to disagree with Caldera?
A. I would just ask them to show me what it's based on.
Q. Do you disagree with them or no?
A. I don't have the knowledge to agree or disagree.
Q. So, you use the Desara because it's --
MR. DeGREEFF: Strike that.

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Q. So the Desara is a mechanical-cut mesh.
Is that correct?
A. Yes.
Q. The TVT-Exact is laser-cut.
True?
A. Yes.
Q. The TVT-Abbrevo is laser-cut?
A. Yes.
Q. And the TVT-O has both laser-cut and mechanical-cut options.
Right?
A. Yes.
Q. You said you worked for Boston Scientific as a consultant.
Is that true?
A. Yes.
Q. When did you start working for Boston Scientific as a consultant?
A. That was a ways back.
So, they sold the device that I helped make was sold in 1996 or '97. So 1998 they asked me to come on since I had helped to make the device together, and we

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started -- I started doing that study about the using that device to make first it was in a scientific role doing studies, the two studies for the sacrospinous suspension and for the mini incisional Burch procedure. And as that relationship grew, we started talking about, you know, how they could improve their pelvic floor products.

I had gone to Ethicon, as the theme continues, I had gone to Ethicon about making the needle smaller and they didn't want to. So we made the Advantage Fit together.

Q. Okay. And, so, that would have been like 1996 that you started consulting with BSC?

A. '96 or '97 is when they sold the device. So my consulting would have started in like '98. Somewhere in that range.

Q. Okay. So you were not consulting with them before they sold the device?

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A. Correct.

Q. So 1998 until when did you stop consulting with BSC?

A. Four years ago.

Q. So 2015-ish? Is that correct?

A. Yeah, around that time.

It's all approximates.

Q. It sounds like were you doing R&D type work for them, or was there some other aspect of it?

A. I was teaching in labs trying to teach people good -- the best technique, or at least my best technique for placing slings and doing the sacrospinous suspension. So a lot of lab work teaching.

I was working on R&D for the slim sling. Wasn't that extensive. We were just making the needle narrow and putting the tube on it. You know, as far as a change, it's a significant change in a product.

They asked for my opinion on some of the -- I was involved in the

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development. They asked for my opinion on some of the vaginal mesh products when they started making those.

Q. So it sounds like they were asking you for input on just kind of the use of the device as well as some R&D aspect.

Is that fair?

A. Product development and teaching.

Q. And you currently use the BSC Advantage.

Right?

A. To a small degree.

Q. And were you being paid by BSC as a consultant for that 17-year span, I'm assuming?

A. Yes.

Q. How much do you think you were paid in that 17 years by BSC?

A. That wasn't high volume per year. I mean, ten a year, approximate.

Q. Ten thousand a year?

A. Ten thousand a year if I was

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involved in a project. Maybe it was 20 on a year where we were more involved in focusing on something.

Q. So, over 15 years, maybe 150 to 200,000?

A. 15 years, yeah, somewhere in that range.

Q. What are the differences between the BSC Advantage sling and the TVT products?

MS. GERSTEL: Objection; asked and answered, I think.

THE WITNESS: Yeah, it was?

I'll answer it.

A. So, the Boston Sci slings are all laser-cut. The central portion of the sling is also heat-treated potentially to make it a little more robust in that area. So it is stiffer for sure.

Other than that, the TVT-Exact and the TVT have a very similar shape, a very similar angle. You know, when I was consulting with Boston Sci, we were basically making a TVT that was skinnier.

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So the shape was similar. The arc of the needle is similar. You know, the porosity of the mesh is slightly different.

I can't tell you what it is, but it's all within the type one mesh characteristics.

Those are the major differences.

Q. You said you did some consulting for AMS.

Is that right?

A. Very little.

Q. When did you start that?

A. It was in the vaginal mesh era. They asked me to come up and do one or two labs to see what I thought of their vaginal mesh. It was a one or two gig thing.

Q. What did they pay you for doing those labs?

A. I think 3500.

Q. Total or each?

A. Each one.

That includes a trip to Minnesota in the winter. So you could say

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I paid them.

Q. So roughly seven grand total with them?

A. Yeah.

Q. Have you done anything with them since then?

A. No.

Q. How many -- since you've been acting as an expert witness for Ethicon, I believe you said you've given your general opinion and then there's been four or five case-specifics.

True?

A. Yes.

Q. Have you ever told Ethicon no when they came to you and asked you to give an opinion on a specific -- in favor of a specific case?

A. Of a case?

I think we had one where, you know, the materials were sent and then they said look at the other ones first because we're working on this. I glanced at the case and looked at some of the key

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things and I said this one may be a tough one, and they ended up closing that case before I ever lent the opinion.

So, there are discussions sometimes where I tell them that, you know, this case looks a little difficult.

MS. GERSTEL: I'll just state not to reveal any discussions with counsel.

THE WITNESS: Right.

BY MR. DeGREEFF:

Q. So they settled that case before you had to say no, basically?

A. I didn't say that I said no. I was evaluating it, but they settled the case before I got deeper.

Q. So the answer is no, you've never told them no on any case they've asked you to be an expert witness on?

A. At this point, no.

Q. In all the case-specific reports you've done for Ethicon, you've ultimately concluded that the product, i.e. the mesh manufactured by Ethicon, was not the cause

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of the plaintiff's complications.

True?

MS. GERSTEL: Object to form.

A. Yes.

Q. Have you ever given the opinion that one of Ethicon's mesh products caused a woman's pain or other complications?

A. Well, the product used by a surgeon and the use of the product not being used correctly is different than the product itself causing the damage. So I never have thought that the product itself caused the damage.

Q. But you've blamed the doctor in some of them, in some of your --

A. I didn't blame the doctor. I assessed the materials and assessed that the technique issues were problematic.

Q. So you blamed the doctor ultimately and said that it was the doctor's fault?

MS. GERSTEL: Object to form.

BY MR. DeGREEFF:

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Q. True?
A. Sometimes it was a technique problem. Sometimes it was a concomitant procedure and it may not be the doctor's fault. If you do a posterior repair, you can have dyspareunia and it doesn't mean the doctor was faulty.
It's a known complication of other gynecologic procedures that happen concurrently with the mesh procedure. So it's not necessarily that I'm blaming the doctor.
Q. Have you ever given the opinion that any mesh product caused a woman's injury?
A. I've never given the opinion that a mesh product separate from the procedure caused an injury.
Q. You've given the opinion that the procedure was somehow done wrong and that was the cause?
MS. GERSTEL: Object to form.
A. If there's a problem with a procedure when you're using mesh, it can

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lead to complications. It wouldn't happen if the procedure was done right.
The mesh characteristics I don't think would have harmed the woman.
Q. Do you have any understanding why you were chosen as an expert witness for Ethicon in this litigation?
A. I've got a good reputation in the field for 23 years. I do good clinical work. I publish. I'm easy to get along with.
Q. And you've been an Ethicon consultant or expert witness for 17 years now.
Is that right?
A. Well, the expert witness now is for about three, three-and-a-half years. And the Ethicon consulting was from, I would have to look back at the transcript. It was probably five to ten years. They're not continuous, but --
Q. Well, you started in 2002 as a consultant for them.
Right?

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A. Approximately that.
Q. You consulted with them until roughly 2012.
Right?
A. Well, I think there was -- in 2012, I think that might have been the -- there was a big gap. So yes, from a time frame, you go to 2012. But I think if you've got the records from when I worked for them, there was a pretty big gap. I was not doing a lot of Gynecare work for a few years and then they asked me and asked me if I would come take a look -- I think there's one data point that's making that look extended. So it may be five to eight years and not twelve years just because I think that 2012 is an outlier. But you'd have to look at -- I know you have the records of everything that I've done. So we'd have to look more closely at it.
Q. So we're looking at eight to eleven years where you were either a consultant or an expert for Ethicon in the last 17.

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Right?
A. Sounds about right.
Q. And you've been using their product since 2000?
A. Yes.
MR. DeGREEFF: We can take a break.
(Recess taken.)
BY MR. DeGREEFF:
Q. Sir, do you remember doing any work for Astellas?
A. Yes.
Q. And what was that?
A. A pharmaceutical company made a drug for the overactive bladder.
Q. Do you do some consulting for them, it looks like?
A. Yes.
Q. And when did you do that?
A. I don't know the exact years. It would probably be like three years ago to six years ago, so.
Q. 2013 to 2016?
A. Yeah.

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Q. Do you have any idea how much you were paid by them?
A. Maybe 5,000 a year.
Q. So maybe 15 total?
A. Yeah.
Q. I want to discuss, you told me earlier you were paid about 50,000 by Caldera.
Do you remember that?
A. Yes.
Q. I want to talk to you about that.
Do you remember being paid $6500 by Caldera in 2013?
A. I wouldn't be able to recall the yearly in this meeting.
Q. Do you know what the open payments data is on the CMS website?
A. I assume it's a public record of what I've been paid for various activities.
Q. Right.
If Caldera reported that they paid you $6,500 in 2013, would you

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disagree with that?
A. I would have to check my records. I don't know that those records are -- I do know that some of the online records of what I've been allegedly paid were wrong.
So, I would say that we are discussing consulting years ago, ranges and payments, and I would suggest that I come up with the actual payments from payroll would be something I'd like to do.
Q. So you want to go chase down for me all of your accounting records for everything you've received from all of these pharmaceutical companies?
MS. GERSTEL: Object to form.
A. Well, I don't know we're -- you know, we're guessing at a lot of activities with a lot of companies across 20 years. It seems like the -- I don't know how on target they would be.
I do know the online stuff, I looked one time it was off by a digit, and we do have to contact them. There was one

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time I had to contact them to make it corrected.
Q. Well, in 2014, do you remember being paid $25,000 by Caldera?
A. I don't remember the yearly number.
Q. Does that sound inaccurate to you?
A. There was a year or two where I was doing a lot of work.
Q. In 2015 do you remember being paid $25,000 again by Caldera?
A. I don't remember the number, but it's plausible. As I said, there were a couple of years where it was heavy.
Q. In 2016, do you recall being paid $18,600 by Caldera?
A. It's certainly possible.
Q. In 2017, do you recall being paid $8,000 by Caldera?
A. That sounds familiar.
Q. So, I get more like $80,000 paid to you by Caldera.
Does that sound accurate to you?

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A. It sounds like the records you have show that.
Q. Do you disagree with that? Does that sound out of line?
A. It may be right. It may be plus or minus 20.
I will go to their accounting and ask them.
It doesn't sound erroneous.
MR. DeGREEFF: Sir, I'm going to hand you what I'm going to mark as Deposition Exhibit 10.
(Lind Exhibit 10, Consulting Agreement dated as of January 3, 2002 between Lawrence Lind, M.D. and Ethicon, Inc., Bates No. ETH.MESH.16009738 to 16009743, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. Sir, does this appear to be a consulting agreement between you and Ethicon?
A. Looks like it.

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Q. What is the date of that?
A. 2002.
Q. January 3rd of 2002?
A. Yep.
Q. Does that sound familiar as about the time you started working for Ethicon as a consultant?
A. It's about where I thought it was.
And it looks clearly it's a document that's real.
Q. If you look at under Section 1 "Consultant," my only question is with that paragraph is there's a spot in it that says: Keep records of hours worked and cost of materials used.
Was that something that you would have done?
A. You know, the consulting for them was not at home working on documents. They would call me to do a lab. It was a half-day lab. They'd pay $3,000 and it was a one-at-a-time thing.
So, there really wasn't any

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recordkeeping. You'd go. You'd submit one at a time. It wasn't a kind of like a cumulative work that was being added that you recorded.
So, I would say I kept records, but it was one at a time, and once you did it, I didn't keep track after that.
Q. So I guess my question is are there any records in existence that would have a detail of the hours worked under this consulting agreement?
A. I don't have it, and I don't know if Ethicon would have it.
Q. Would that have been something you would have submitted to Ethicon?
A. As I said, it was a one-day-at-a-time type of working agreement. So even though it's instructing to keep hours, I think that's requesting to kind of keep the accounting in order. The way I worked, it was just a, you know, once every few weeks or few months they asked me to come to do something and I went and I submitted for

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that one day.
So, there were not -- there aren't records, I don't have a spreadsheet or a record of the hours worked.
Q. Okay.
I don't see that I ever asked you that, but how much do you think you were paid by Ethicon as a consultant? Not as a expert witness, but as a consultant?
A. I don't know. It started a long time ago. Spanned a long period. There were periods with big gaps where I didn't do much at all, and there were periods where I did a lot.
So I really cannot conjure a guess. I don't know if it's 20,000 or a hundred thousand. I really don't know.
Q. And who would know that answer, if not you?
A. I don't know if Ethicon has the records or if their accounting goes back that far.
Q. So, if you look at page 3 of this agreement, the term of the agreement

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commenced on January 3rd of 2002 and seems to have terminated on February 28th of 2002.
Do you have any idea why it was so short?
A. You know, I'd have to read the whole agreement.
As I recall, there was a time where anyone -- the contracts they had had things that said you couldn't work with anyone else. So, I said well, you know, I have ideas I'm working on and you're rejecting them. So, I don't know if that's why.
So this may have been made because I didn't agree to some of the terms of their long-term agreement, but they wanted me to come for this one session, so we made a short-term contract.
So it does seem odd.
Q. I think the situation you're talking about was in 2010.
And maybe if you turn to page 4 of Exhibit 10, that will kind of clarify

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it for you. If you look at 6 and 7, paragraph 6 and 7.
A. Yeah, it looks like it's an invitation to go to one session, abdominal guides training session.
Q. That's what I was going to ask.
So, it looks like they were paying you $3,000 for coming to a abdominal guides training session?
A. Right.
Q. Did you get that $3,000 just to show up, or did you have to teach?
A. I was definitely teaching abdominal guides. They weren't -- I would be one of the people teaching it, not learning how to do it.
Q. How long was that training session?
A. They usually were a half-day to six hours. Four to six hours.
Q. Where did those take place?
A. They were in a number of locations. It was various places that had access to cadavers. So I don't know where

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it took place, but the closest it would be in 2000 -- it wasn't on Long Island until later in our agreements because we didn't have cadaver labs. So it would either be Manhattan, New Jersey.
Q. Somewhere in the New York metropolitan area?
A. Yeah. I wasn't flying for this.
Q. And they were essentially paying you $3,000 for a half-day participation?
A. Well, as I said, it would be four to six hours, plus the transportation and time. So, you know, door to door, it would certainly be more than eight hours.
Q. Did they pay you for your transportation and hourly rate also?
A. They paid the amount and then just incurred costs for transition. It wasn't an hourly rate on top of that.
Q. So $3,000 for roughly eight hours.
Is that right?
A. Yeah.
MR. DeGREEFF: I'm going to hand

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you what I've marked as Deposition Exhibit 11.
(Lind Exhibit 11, Clinical Study Agreement between Gynecare and North Shore University Hospital, Bates No. ETH.MESH.00412092 to 00412098, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. Can you tell me what that is?
A. Clinical study agreement.
Q. And the term of that agreement is April 4th, 2002 through the end of June, through June 30th of 2004.
Correct?
A. Right.
Q. This was between Gynecare, which is a division of Ethicon, correct?
A. Yes.
Q. And your institution with you and Dr. Garely designated as the, looks like, the primary people in charge of this?
A. Investigators.

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Q. Is that correct?
Who is Dr. Alan Garely? Do you know him?
A. He was a previous partner in my practice, and he now practices in Manhattan and south shore of Long Island.
Q. Do you know him personally?
A. You know, I mean, we were partners for three years. So I did know him personally. We don't socialize at present.
Q. Is he a good doctor?
A. He's a good surgeon. I don't think -- again, I haven't seen him take care of patients in 15 years.
Q. I mean, do you have any criticisms of him as a physician?
MS. GERSTEL: Object to form.
A. He could get upset with someone, and then it wasn't a good scene.
Q. Okay. That's not really him as a surgeon. It sounds like maybe you --
A. I haven't seen him in a practicing situation for 15 years. So I

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really don't think I can say anything.
Q. Okay.
So, Dr. Garely was one of the investigators hired by Ethicon to do this clinical study agreement with you --
A. Yes.
Q. I mean to do this clinical study with you.
Do you know when was the last time you spoke to Dr. Garely?
A. A couple months ago.
Q. Do you know whether he currently uses the TVT-O, TVT or TVT-Abbrevo?
A. I don't.
Q. Have you ever been provided with any of the testimony or documentation of what he told Ethicon about those devices?
A. I think I saw one of his mesh reports. I don't think I saw a sling report.
Q. So, as you sit here, do you have any idea what he told Ethicon about the TVT-O, TVT-E and TVT-Abbrevo?
A. I don't.

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Q. Is it your understanding that Dr. Garely is now a plaintiff's expert in the transvaginal mesh litigation?
A. I do understand that.
Q. And you reviewed his report?
A. I reviewed his mesh report.
Q. When you say "his mesh report," are you talking about with regard to the Prolift?
A. Yes.
Q. So, this is a former consultant, or I guess someone who is a former investigator on a study done by Ethicon who's now providing testimony for the women injured by Ethicon devices.
Is that right?
MS. GERSTEL: Object to form.
A. Looks like he was a previous participant in this study and he is now a plaintiff's expert, as you described.
Q. Well, plaintiff meaning the women who are claiming injuries.
True?
A. Yes.

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Q. If you look at paragraph 1 where it says: Performance of study.
As the principal investigator, you were to perform the study in accordance with the protocol.
Right?
A. Right.
Q. Who determined the protocol?
A. I would have to look at the protocol to comment on that. But I would say that any study I enrolled in, I would have to believe that it was a protocol that I agreed with. So there can be suggestions from a company as to what they might want to happen, but I would never have a -- subject my patients to any protocol that I didn't specifically take responsibility for if I was a principal investigator.
Q. Well, Ethicon determined the protocol that was used.
Right?
A. I am ultimately responsible for the protocol that gets submitted to the

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IRB.
Q. I understand.
A. How much of the protocol was created by them and edited by me or created totally by me I don't think we can answer at this meeting.
Q. If you look at paragraph 3 "Financial Consideration and Payment Schedule."
You see where I'm at?
A. Mm-hm.
Q. It says: The total price for the conduct and the completion of study as well as the payment schedule is outlined in Schedule B.
Did I read that correctly?
A. Yep.
Q. Look at Schedule B, if you would. It's on page 6.
Are you there?
A. Yes.
Q. It appears that the total payment being made by Ethicon is $11,000.
Is that correct?

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A. That's the planned -- that's the budget for the -- for the study. Right.
How much was actually paid with how many subjects, we don't know. This is the schedule of payments ahead of time of what would be paid. Each line item would have to be carried out to be paid that. It's not paid in advance, so.
Q. Okay. That's the projected $11,000 for the payment for the study?
A. Right.
Q. And this was between 2002 and 2004 that you were conducting this study?
A. Yes.
Q. So, the title of the study is "A clinical assessment of patients undergoing Gynecare TVT with abdominal guides for the treatment of stress urinary incontinence."
Correct?
A. Right.
Q. And what was the ultimate goal of the study?
A. You know, they had a retropubic sling, the standard TVT that went from

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bottom up, from the vagina upward, and there were a -- from the urology teachings of slings of long ago, there's a different way of passing a sling that started from the top down, which a lot of urologists favor. So the -- it was a design of an instrument by Gynecare to try to add that to their product line and to give those who felt that that was a safer passage the opportunity to go from the top down.
So, the purpose of this study was to look at efficacy of safety of a sling that went from the top down rather than the bottom up.
Q. And what was the result?
A. I don't think it got off the ground and got enough numbers for enrollment, because I don't think I ever saw a publication from it.
MR. DeGREEFF: Sir, I'm going to hand you what's been marked as Deposition Exhibit 12.
(Lind Exhibit 12, Secrecy Agreement dated January 19, 2004

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between Gynecare and Lawrence Lind, MD, Bates No. ETH.MESH.09464276 to 09464279, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. Can you tell me what that is?
A. It's a privacy agreement to discuss intellectual property.
Q. It's actually better than that. It's called a Secrecy Agreement.
Right?
A. That's how they titled it.
Q. And that's between you and Gynecare.
Correct?
A. Right.
Q. And Gynecare is a part of Ethicon?
A. Yes.
Q. I want to ask you a couple of questions. First is in paragraph 1 on the front page.
You see where I'm at?
A. Yep.

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Q. It states that it's to determine whether to enter into a mutually attractive business arrangement.
Did I read that correctly?
A. I see it.
Q. What does that mean? What was the mutually attractive business arrangement that you were trying to decide whether to enter into with Ethicon?
MS. GERSTEL: Object to form.
A. This is 2004. So this may have been when I wanted to propose to them the slim modification of the TVT. So I was disclosing some personal information that I didn't have intellectual property on, but I had drawings. I had writings. I had sealed documentation that I had come up with this idea.
So, I don't know for sure, but I think that this is a scenario to sit down and talk about an idea that I had. And, you know, usually in this situation, if a company likes your idea, then they purchase it from you and there's a

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business arrangement made. I've never had one of those arrangements, but I'm extrapolating. I can't say for certain that's what we were doing here. But this sounds like a scenario where I'm presenting them with an idea and they're going to decide whether there's something mutually agreeable that would come out of this.

MS. GERSTEL: I'm just going to place a late objection that that -- I believe that that's a mischaracterization of the document and the agreement.

BY MR. DeGREEFF:

Q. So, would you have been asking them to partner up on your idea? Is that kind of what you were doing?

MS. GERSTEL: Object to the form.

A. Well, when you have an idea, you want to present it. And I'm not in a position to take a idea and make it into a sling. So you go to a reputable company

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that's right now the leader in sling products, and you bring your idea to them to see whether they like it.

So, partner up, you could call it partner up or you could call it a routine scenario where someone with an idea brings an idea to a company and if it's deemed valuable, there's a business arrangement made to purchase the intellectual property and there's a financial arrangement made with them.

Q. Well, if they're the leader currently, then why didn't you go to them with your current device? Why did you go to BSC and Caldera instead?

A. Because my relationships with them are more current.

Q. It states: The parties further agree not to disclose the relationship between the parties or the existence of this agreement to any third party without the consent of the other.

And there's a three-year effective date on that.

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Did I read that correctly?

A. Yeah.

Q. So, you weren't even, under this secrecy agreement, you weren't even allowed to disclose that you had a relationship with Ethicon.

Is that what this says?

A. It says that I would have to tell them if I was telling someone else.

Q. So, when you were offering your patients the TVT sling devices, did you disclose to them that you had a consulting relationship with Ethicon and several other sling manufacturers?

A. I did and I do.

Q. Did this prohibit you from doing that?

MS. GERSTEL: Object to the form.

A. No.

Q. Why do you disclose your consulting relationship with Ethicon and other sling manufacturers to your patients?

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A. Because I want to make sure I have a discussion that lets them know I work towards betterment and improvement of these products all the time. That means I work with the companies. And there are payments made sometimes for that consulting work, and I don't want them to discover that and feel that I hid something that they would think was, you know, financial motivation. I tell them the relationship. I tell them why I use the product, and I tell them why I'm working with them.

Q. Okay.

A. Seems like the responsible thing to do.

Q. Right.

Because being paid by somebody can create a bias towards using a product.

Right?

A. Correct.

MR. DeGREEFF: I'm going to mark for you Deposition Exhibit 13.

(Lind Exhibit 13, e-mail chain

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ending June 15, 2004, Bates No. ETH.MESH.11003781 to 11003783, was marked for identification, as of this date.)

BY MR. DeGREEFF:

Q. So, I have handed you what appears to be an exchange, an e-mail exchange from it's the June of 2004 date range.

Does that look accurate?

A. This is 2004 communications, right.

Q. And if you look at the initial two e-mails on the chain, meaning the earliest in time, you are a recipient on, I guess two of the three earliest you're a recipient on those e-mails.

Correct?

A. Please find the attached signed contract for your Gynemesh procedure videos. The original and copies have been sent to Jeff Kraut by the courier.

I see that.

Q. And if you look the "to" line,

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this e-mail was sent to you.

Correct?

A. Which line?

Yes.

Q. And who is Giselle Bonet?

A. I don't recall.

Q. And the subject line of this exchange is called "Procedure Videos Signed Contract."

Did I read that correctly?

A. Yep.

Q. I mean, did you do some form of a video for Ethicon?

A. I don't think I did a beginning-to-end video. I think perhaps maybe in a lab they were filming some steps of anatomic passage of something.

I -- I don't -- I cannot recall a video that's got my name on it or in the credits that the video maker of one of these sling videos.

I think that sometimes when you go to their labs and you work on stuff, they ask you to sign permissions, or if,

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you know, maneuvers you've done or -- or anatomy you've shown might be used for videos, and this might be like a little segment video permission.

But I do not recall a video with my name on it that I made for -- you know, beginning to end for Ethicon.

Q. Well, if you look a little further up in the chain on the same page, there's an e-mail to you that says: Larry.

That's you, right?

A. Yeah.

Q. (Reading) Would like to process this payment in June. Need paperwork back before 6/21.

Did I read that correctly?

A. Yep.

Q. So, were you paid to do this video?

A. I don't know what I was doing there. There's some -- I don't know -- I don't know what this -- I don't know what this is.

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Q. Okay.

A. I really don't know what it is.

Q. If you look on the next page, there's an e-mail -- I mean on the front page, I guess. There's an e-mail to you on June 11th from Marianne Kaminski with Ethicon stating: We have the signed contract. We will process the payments.

Did I read that correctly?

A. Okay.

Q. So, appears you were paid for doing a Gynecare -- excuse me. A Gynemesh procedure video.

Right?

A. There's something I was doing that was either used as part of a video or participated in making a video. But as I said, I don't recall.

As I've described it, it could just be segments of something I did in a lab that was filmed.

I don't believe that I made them a video from beginning to end. But I was clearly, by this set of e-mails, paid for

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work I did that was used as or as part of creating a video.
Q. I really ask because I'm wondering if I'm in the presence of a movie star. That's really where I was going with that. And if I could get an autograph maybe later.
A. Well.
Q. All right.
A. But I do look like a couple of them.
MR. DeGREEFF: Sir, I'll happened you what I've marked as Deposition Exhibit 14.
(Lind Exhibit 14, Q CDA Log, Bates No. ETH.MESH.15359953 to 15359976, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. This is titled "Q CDA log."
Have you ever seen this before?
A. May have.
Q. If you look on page 11, the Bates number at the bottom of it has a

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last three of '963.
A. Are they numbered?
Q. Down here (indicating). The Bates number ends in '963. That's called a Bates number.
A. Okay.
Q. If you look at the second column over, it says: With whom.
A. Got it.
Q. And then one, two, three, fourth one down says: Dr. Larry Lind.
I'm assuming that's you?
A. Yes.
Q. And that shows that there's a topic next to it that says: Evaluating information for discussions regarding device evaluations.
Do you know what that means?
A. Sounds like I'm looking at their devices and discussing it.
Q. If you look at the column next to that, it says "type" and "SA" is written.
Do you know what that means?

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A. Nope.
Q. Does it mean secrecy agreement?
MS. GERSTEL: Objection.
A. I don't know.
Q. Then there's a column further over that has a term that says "term" and it says "3."
Do you see that?
A. Yep.
Q. And it shows date and years columns that says 12/19/2009 to 12/20/2012.
Do you see that?
A. Yep.
Q. So, were you under some form of an agreement with them from 12/19 of 2009 to 12/20 of 2012?
A. Looks like they have a contract. I don't know if this CDA log is accurate. I'd like to see that contract.
I can certainly tell you between those years, I do not have a lot of activity with them. That's for sure.
Q. If you look at the originator

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column, who is V. Zaddem?
A. I don't know what her position is now.
I recall her name.
Q. Is it an Ethicon employee?
A. I assume it was someone organizing or handling the contract, but I don't know who it is.
Q. Do you know who Pete DeCosta is?
A. I do not.
Q. During this three years --
MR. DeGREEFF: Strike that.
Q. Do you have any idea how much you were being paid under this three years of contracts?
A. I think there were very few events. I was usually paid in the same amount by them.
Q. The person below you on this list is Dr. Elizabeth Kavaler.
Do you know her?
A. Yes.
Q. How do you know her?
A. She was a urologist in

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Manhattan. So we -- I get some of her patients, she gets some of mine, and when we do this Pelvic Floor Society meeting in the city, she sometimes attends. I think she was -- I think she was at the Prosima lab that I did with them in this time period, and I think that was probably the only thing that I did with them in this time period. I'm guessing, but I remember I wasn't doing a lot. And they really wanted me to look at this Prosima.

Q. Are you aware that she's also a witness for Ethicon in the transvaginal mesh litigations?

A. Yes.

Q. And you're aware that she was also a consultant for Ethicon prior to becoming an expert witness?

A. Yes.

Q. Are you aware of any expert witness for Ethicon in this litigation that was not a paid consultant first?

MS. GERSTEL: Objection.

A. I don't have an answer to that.

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Q. Then if you look a couple pages later where it says '965 as the last three of the Bates number.

A. Okay.

Q. There's another in the column that says with whom, if you go four down, it says "Lawrence Lind."

I'm assuming that's also you?

A. I see it.

Q. And the column that says "topic" says: Provide consulting services to Ethicon on behalf of Ethicon.

Did I read that correctly?

A. I see it.

Q. It looks like you were under a master consulting agreement from 8/31 of 2010 to 12/31 of 2011.

A. I see it.

Q. Does it sound accurate?

A. Yes.

Q. What did you do for Ethicon as part of the consulting services from 2010 to 2011?

A. I don't recall.

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Q. So, this was a second agreement with Ethicon that was covering the years 2010 to 2011.

Right?

We just looked at another one.

A. Those are the dates.

Q. So, during that time period, you had multiple agreements with Ethicon?

A. It looks like I had these two.

MR. DeGREEFF: Sir, I'm handing you what I've marked as Deposition Exhibit 15.

(Lind Exhibit 15, e-mail chain ending October 1, 2010, Bates No. ETH.MESH.03642725 to 03642726, was marked for identification, as of this date.)

BY MR. DeGREEFF:

Q. Sir, I acknowledge that you are not on this document. And really what I want to ask you is there's a discussion here about you, about your contract, in which some employees of Ethicon state they're going to look to terminate the

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marketing contract with you.

Do you see where I'm at on that?

A. Looking to terminate it.

Q. Yes.

A. Okay.

Q. Do you see where I'm at?

A. Yep.

Q. And it looks like the reason, based on the e-mail above that, the reason that they wanted to terminate the marketing contract is because you had signed an R&D agreement under which you were going to get a different rate.

Right?

A. I wasn't aware as of this date that I had a marketing agreement. My understanding was always as consulting services for education and research and development. So I would need to see the marketing agreement. I haven't seen anything that we've looked at today that says marketing.

I do see here that they seem to feel that I had one and that they want to

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change it.
Q. Why do you think they considered you to have a marking contract?
What kind of marketing were you doing for them?
MS. GERSTEL: Objection.
A. I wasn't.
Q. Were you giving lectures for them?
A. In labs I would teach the surgery and give educational lectures. I consider that education. If you consider it marketing at the same time, that's a -- I don't know if that's a legal term or a judgment call of what you're doing, but I was educating.
Q. In 2010, you were, based on this e-mail, you were also consulting for Boston Scientific.
Right?
A. Yes.
Q. And you were wanting to craft the language of your consulting --
MR. DeGREEFF: Strike that.

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Q. You were wanting to craft the language of your R&D agreement with Ethicon to avoid any conflict to what you were doing for Boston Scientific.
Is that something you remember?
MS. GERSTEL: Objection.
A. Yes. The contract said I couldn't work with anyone else on slings or incontinence materials, but I was already doing that with Boston Scientific. So I asked them to restrict the scope to repair a prolapse.
Q. And if you look on the earliest e-mail on this exhibit, it says: There's a master consulting agreement for Dr. Lind.
And it says: The contract term is one year beginning 2/25/10 and ending 2/25/11.
Did I read that correctly?
A. Yep.
Q. So that would be a third contract during that same time period.
Right?

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A. That's what the e-mail says.
I haven't seen any contracts.
MR. DeGREEFF: Sir, I'm going to hand you what I've marked as Deposition Exhibit 16.
(Lind Exhibit 16, e-mail chain ending April 28, 2010, Bates No. ETH.MESH.02033638 to 02033639, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. This again, this is an e-mail about an edit you were requesting to a contract in April of 2010.
Right?
A. Yep.
Q. If you look at this first e-mail, the longer one, it says: I found Dr. Lind has existing contacts with ProfEd and marketing activities for product evaluation, written materials, market reviews, advisory boards and company sponsored speaker programs at a rate of $1500 a day.

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Did I read that correctly?
A. Mm-hm.
Q. Company sponsored speaking programs, were you speaking on behalf of the company, of Ethicon?
A. Only at labs.
Q. At labs?
A. Yes.
Q. And again, they're considering you to have a contract for marketing activities.
Right?
A. It does indicate that. I do not recall ever working on marketing.
Q. Certainly it appears that Ethicon believed that they had a marketing contract with you.
Right?
MS. GERSTEL: Objection.
A. I think what happened is we got involved in a time frame where companies and hospitals and doctors started recognizing compliance, and so that wording had to be very specific. So, they

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might have had stuff in the previous agreements that had to do with marketing, et cetera, et cetera, which is consulting that I do not do. I only do work with the R&D people. In fact, I don't interact with the marketing people. It's part of the rules.

So this is, I think, something to get the accounting and compliance in order that my role is for R&D, which is what it always was.

Q. Whatever the case may be, we looked at multiple e-mails now where Ethicon refers to one of their contracts with you as a marketing contract.

Right?

MS. GERSTEL: Objection.

A. I think those referrals to my contracts and my role in there are wrongly described.

Q. Regardless, that is the terminology Ethicon is using, right?

A. And I am challenging it.

Q. Then if you look at down below

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there's an asterisk that says: These activities are unique to Dr. Lind because he uses competitor devices regularly.

Did I read that correctly?

A. Yes.

Q. And as we discussed earlier, you use primarily the Caldera device currently.

Right?

A. Currently.

At the time of this contract, I think they were more interested in the cadaver lab projects I did with Boston Scientific.

Q. Gotcha.

So, this says: Here is what I recently learned from Scott Jones in marketing.

Do you know Scott Jones?

A. No.

Q. It says: In 2009, the doctor agreed to $1500 a day for Ad Board work, which was the rate all participants received for that event.

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Did I read that correctly?

A. Everything you're reading you're reading correctly.

Q. So, were you being paid $1500 a day for advisory board work?

A. That's what it says.

Q. And what does that advisory board work mean?

A. You come and look at products. You may be in a lab working on development, discussing the products in the setting of a cadaver lab. You may be sitting around a table with other experts holding mesh, feeling mesh, holding devices, giving feedback as to what works, what doesn't work, which directions can they go.

Q. And then the last sentence on this page leading to the next page says: Over the past weekend, doctor made a comment to one of our associates that he was angered that he had signed at such a low rate. Especially since he is compensated by our competitors at $3,000 a

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day for working with R&D.

Did I read that correctly?

A. Yes.

Q. So, you were upset that you were only getting paid $1500 a day by Ethicon when your competitors were paying you $3,000 a day.

Right?

MS. GERSTEL: Objection.

A. I see the facts that are on this sheet.

Q. Is that your recollection?

A. I don't have independent recollection.

Q. Do you have any reason to dispute this?

A. Not really.

Q. And what competitors were paying you $3,000 a day in 2009 and 2010?

A. Probably Boston Scientific.

Q. It also says: Also, this surgeon has tried our pelvic floor products many times, but he prefers to use our competitors' products.

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Did I read that correctly?
A. Yes.
Q. And then they go on to say: What I found out is that ProfEd - I guess professional education - and marketing used to use Dr. Lind heavily as a KOL similar to how Dr. Vincent Lucente is consulted currently. However, they do not anticipate his services as specified in his existing contracts because he does not use Ethicon's PFR kits.
Did I read that correctly?
A. Yep.
Q. Do you know what a KOL is?
A. Key opinion leader.
Q. Were you a key opinion leader for Ethicon?
A. I was a consultant. If they called me that, they chose to call me that.
It wasn't a badge you earned.
Q. Do you disagree that you were a key opinion leader for Ethicon?
A. I think at times they thought I

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was and at times they thought I wasn't. When I came to them with the slim sling design, they told me to get lost, so.
Q. Okay.
A. My opinions weren't very well-respected or received then.
Q. So you were a key opinion leader for Ethicon when you were agreeing with them.
Is that what you're saying?
MS. GERSTEL: Objection.
A. I don't have an answer for that.
Q. And it seems here that professional education and marketing were using you heavily.
Correct?
A. That's what it reads.
Q. Who is Dr. Vincent Lucente?
A. He's a urogynecologist in Pennsylvania.
Q. Was he a key opinion leader for Ethicon?
MS. GERSTEL: Objection.
A. I guess he was.

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THE WITNESS: I'm sorry. I know time is getting tight. I'm going to use the restroom.
MS. GERSTEL: Okay.
(Recess taken.)
(Lind Exhibit 17, e-mail chain ending May 10, 2010, Bates No. HMESH_ETH_03111719, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. Sir, I've just handed you what I've marked Deposition Exhibit 17.
Do you see that?
A. Yep.
Q. This is some e-mail exchanges from April of 2010.
Correct?
A. These are e-mails from 2010, yes.
Q. And the first e-mail on the chain is an e-mail that you sent to Vincenza Zaddem.
Right?
A. I reviewed the contract.

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Q. If you just look at the to/from line and the e-mail.
A. Yeah. I see the one with me to Zaddem, yes.
Q. And who is Zaddem?
A. I don't know.
Q. Really my only question is if you look at that, you say: I reviewed the contract.
Correct?
A. Yes.
Q. And then under item 17, the paragraph that starts with the words "item 17," the last sentence is: The value of the contract does not justify exclusive services.
Did I read that correctly?
A. Yes.
Q. What was the value of this contract?
MS. GERSTEL: Objection.
A. The value of the contract had standard terms of just hourly rate for -- for work done. It entire set -- this

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entire conversation is about what we were eluding to before insofar as I do consulting with other companies on incontinence and prolapse. The way that they had the contract written, I wouldn't be able to work with anyone else on incontinence and prolapse. So what I was telling them was that you need to, as you have in the previous one where it says the contract must be limited to anchoring devices for prolapse, something specific that we're working on that makes it specific to what I'm doing for Ethicon, because I couldn't sign the contract because it made it so I couldn't work with anyone else. It wasn't like I was being offered $40,000 or some big sum to have an exclusivity arrangement.

What I meant by exclusive services meaning exclusive of other companies. That's just a standard contract. Didn't work.

So, you know, I remember this freshly now.

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We went back and forth, back and forth. And they said, Everyone just signs these. I said, Well, maybe everyone doesn't read it. If your contract says I can't work with anyone else, then I won't work with anyone else. So if you want me to look at these anchoring devices, which is what they wanted me to do, then make the language for the anchoring device, but don't make it to cover that you can't work on anyone else for anything else that you do.

So really it was just the wording of their contract meant that I could work with anyone on incontinence and prolapse, and I was asking them to make a contract that was just specific to what they wanted me to look at, which was an anchoring device.

Q. And these amounts you're being paid for consulting work, that's above and beyond what you're being paid as a physician.

True?

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A. Yes. With the only clarification to make when we went to the -- when we were doing the study, the study payments are a hundred percent paid to the hospital research fund, and there's no compensation part out of that for me.

Q. Okay.

And what amount would have justified exclusivity?

A. I actually -- it's -- I wouldn't do that. I think with -- you've just gone through a whole bunch of papers showing that I've worked with a lot of different companies on consulting arrangements, and what I'll tell you is that when I have an idea and I find the person I can work with on it, I go there. So it's not a matter of trying to just make money off of everyone. There's different opportunities at different times with different companies are ready for different ideas.

So -- so, I never considered an exclusive agreement with anyone, which is why I contested the wording in the

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contract.

Q. Everything we've gone through, I mean, you've been paid over half a million dollars as on behalf of the transvaginal mesh world, if you will.

Right?

MS. GERSTEL: Objection.

BY MR. DeGREEFF:

Q. The manufacturers?

MS. GERSTEL: Objection.

MR. DeGREEFF: Strike that.

I'll reword that.

Q. Based on everything we've been through, you've been paid over a half million dollars by transvaginal mesh manufacturers.

True?

MS. GERSTEL: Objection.

A. I don't know if that's accurate. It's definitely in the hundreds of thousands. I don't know how many it is. I would have to be -- I don't know how many occasions I saw each of these Gynecare contracts. I don't have the

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listed payments for. There's a lot of years of contracts, and I'm not sure how frequent those were.
Q. Well, when you add in what you've been paid as an expert witness, it's pretty clear you've been paid over a half million dollars by the transvaginal mesh industry.
Right?
MS. GERSTEL: Objection.
A. You may have been adding those. Somewhere between 300 and 600 I would agree with somewhere in there. I just don't want to agree to a number that I haven't quantified with a little more conviction.
MR. DeGREEFF: I've handed you what's been marked as Deposition Exhibit 18.
(Lind Exhibit 18, Master Consulting Agreement between Lawrence Lind and Ethicon, Inc. Dated July 10, 2010, Bates No. ETH.MESH.06216861 to 06216869, was marked for

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identification, as of this date.)
BY MR. DeGREEFF:
Q. Sir, do you see that this is a master consulting agreement between you and Ethicon?
A. Right.
Q. And it's dated July 10th -- well, it says it commences July 10th of 2010 and continues through December 31st of 2011?
A. Right.
Q. My question is if you look at where it's Bates numbered '868 at the bottom.
A. Okay.
Q. This talks about the fact that you're being retained, the box where it says yes, you're being retained at a rate of $437.50 per hour.
Correct?
A. That's what it says.
Q. And it lays out the description of your services and the fact that it will be an estimate of 120 hours of work

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maximum over the life of this contract?
A. That's what it says.
Q. And that's the estimate, obviously.
A. Yes.
Q. And then it says: The parties agree that compensation paid to consultant shall not exceed $52,500 per contract term.
A. Right.
Q. Did I read that correctly?
A. Yes.
Q. And the contract term was a little over a year.
Is that right?
A. Yes.
Q. Were you paid this full $52,500?
A. I would strongly doubt that in 2010.
Q. If you could look at the next page. I guess they were authorizing you to be paid 52,500 for the year under this contract.
Right?

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A. They were offering that to be a max based on the hourly fee.
Q. If you look at Exhibit B, this is titled "Conflict of Interest Certification"?
A. Yeah.
Q. And it states, and this is supposed to be from you.
Correct?
MR. DeGREEFF: Let's do this. This one is unsigned. So let's give you this one.
Sir, I'm going to hand you what's been marked as Deposition Exhibit 19.
(Lind Exhibit 19, Master Consulting Agreement between Lawrence Lind and Ethicon, Inc. Dated August 31, 2010, Bates No. ETH.MESH.02030557 to 02030566, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. Deposition Exhibit 19 is another master consulting agreement between you

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and Ethicon.
Correct?
A. Right.
Q. And it's dated -- it says it commences August 31st of 2010 and continues through December 31st of 2011.
Right?
A. Yeah. This is kind of confusing that they have like fresh contracts every month.
But be that as it may.
Q. Right.
And this contract is signed by you.
Correct? Bates number '562.
A. Yes.
Q. Then if you look at Bates number '564, this has the same language about payment to you.
Correct?
MS. GERSTEL: Objection.
A. Right.
Q. Again you're being paid $437.50 an hour?

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A. Yep.
Q. And you've got another maximum cap of $52,500 per contract term?
A. Correct.
Q. Again, that contract term is a little over a year?
A. Okay.
Q. Is that correct?
A. Yes.
Q. Then if you look at the next page, it's got an Exhibit B titled "Conflict of Interest Certification."
Correct?
A. Right.
Q. And that is signed by you?
A. Yes.
Q. And that includes language that states: In assuming contractual obligations to Ethicon Inc., the undersigned health care professional.
That's you, right?
A. Yes.
Q. (Reading) Agrees that financial ties between the health care professional

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and industry may create conflicts of interest, both real and perceived.
Did I read that correctly?
A. Yes.
Q. This is essentially Ethicon acknowledging that payments to physicians, such as --
MR. DeGREEFF: Strike that.
Q. This is Ethicon acknowledging that payments to physicians can create conflicts of interest.
Right?
MS. GERSTEL: Objection.
A. Got it.
Q. Is that correct?
MS. GERSTEL: Objection.
A. Which sentence are you reading again?
Q. Where it states: The undersigned health care professional agrees that financial ties between the health care professional and industry may create conflicts of interest, both real and perceived.

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A. Okay. I agree. I agree that's what it says.
Q. And is this essentially Ethicon acknowledging that payments to physicians can create conflicts of interest?
MS. GERSTEL: Objection.
A. That they may create conflicts of interest, yes.
Q. We just talked about you've been paid between 300 and 600,000 by the transvaginal mesh industry.
Right?
MS. GERSTEL: Objection.
A. By estimates, it seems it would be in that range.
Q. And you've been a consultant for four transvaginal mesh companies.
Right?
A. Yes.
Q. You've been a consultant for Ethicon.
Right? True?
A. Yes.
Q. Caldera?

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A. Yes.
Q. Boston Scientific?
A. Yes.
Q. AMS?
A. Yes.
Q. And you've been referred to as a key opinion leader for Ethicon products by internal Ethicon employees.
Right?
A. Yes.
Q. And you've been referred to as having a marketing contract with Ethicon by Ethicon employees.
Right?
A. Referred to, yes.
Q. And we've looked at multiple consulting agreements that you've signed with Ethicon.
True?
A. Yes.
Q. And you've signed a conflict of interest statement from Ethicon based on the fact that payments to health care providers can create conflicts of

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interest, both real and perceived.
Right?
A. Correct.
Q. Despite all of that, you were ultimately hired by Ethicon to act as a expert in this litigation.
Right?
MS. GERSTEL: Objection.
A. I'm not sure why it's despite this. But I was hired by Ethicon to be in this role that I am now.
I'm not sure how your one thing with the word "despite," I'm not sure how that fits into the question.
Q. You've now been hired by Ethicon to serve as an expert in this transvaginal mesh litigation.
Right?
A. Yes.
Q. And do you have any understanding of why Ethicon did not get a physician who did not have a consulting agreement with prior to hiring them as an expert witness in the litigation?

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MS. GERSTEL: Objection; lack of foundation.
A. I would be conjecturing. I don't have factual knowledge.
Is there a question on this?
Q. We had several questions on it.
A. Okay.
MR. DeGREEFF: Last I want to show you Deposition Exhibit 20. I so marked that.
(Lind Exhibit 20, EWHU HCP Cognos report run 11/17/10, was marked for identification, as of this date.)
BY MR. DeGREEFF:
Q. If you look at the second page, you'll find your name towards the bottom.
A. Okay.
Q. This shows two separate -- this reflects the two separate contracts of 52,500.
Correct?
A. Right.
Q. For a total of 105,000?
A. Right.

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Q. So you had been authorized by Ethicon for up to $105,000 of payment for a little over a year.
Right?
MS. GERSTEL: Objection.
A. I think this is misleading. The maximal allowed in the contract was that amount, and this reflects nothing in the way of what I actually received.
Q. That wasn't my question.
You were authorized by Ethicon for up to $105,000 worth of payment in one year.
Right?
MS. GERSTEL: Objection.
A. If I worked $437 an hour to get to $105,000.
Q. Okay.
Or if they wanted pay you $3,000 to show up to a lecture.
Right?
MS. GERSTEL: Objection.
A. The contract had an hourly rate.
Q. Okay.

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Why was there two different agreements? Did you use all of one of them?

MS. GERSTEL: Objection.

A. It looks to me like on the first one I hadn't signed the institutional compliance that I -- that my working for them did not violate institutional compliance for doing consulting work.

So one of them had a signature and one of them did not. So I think they sent a whole new contract to have me sign that last page, is what I -- it looks like to me from the two.

Q. Why does this spreadsheet reflect that you had two separate --

MS. GERSTEL: Objection.

A. Well, we looked at two separate ones, and you'll see one of them the last page is not signed and one of them the page is signed. So they made two contracts for that amount. I'm guessing that the first one they considered to be legally not binding because I didn't sign

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that required field, and they made another one and it's showing up on here because two contracts were drawn.

But it's -- it's line items on a spreadsheet. I can't account for them. I can -- I am 1,000 percent sure I didn't come anywhere close to this kind of money from 2010 on with Ethicon.

Q. That assumption is based on -- what you just said requires us to assume that we have received all of the documents that we would need to show the signing of that contract.

Correct?

MS. GERSTEL: Objection.

A. Yeah, I agree. We don't right now between us have the accounting accurate payroll of what was paid. But just knowing what I was doing with time in 2010 onward, I feel fairly confident, but I don't have your objective proof, that I came nowhere near that, but I am very confident of that.

Q. Is there a single long-term

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randomized controlled trial specifically addressing the TVT-O?

A. TVT-O has in the range of 40 to 50 randomized trials. I'd have to go through them to figure out how far the long-term is.

Q. What about a single randomized control trial specifically addressing the TVT-O with safety as the primary endpoint?

MS. GERSTEL: Objection.

A. Safety is a primary endpoint in many of the randomized controlled studies. Whether they listed efficacy first and safety as second, I would have to go through each report, but safety was reported in a very large number of them.

I will agree that in some of them the adverse events data was not accurately reported, which is why we rely on Cochrane and excellent meta-analysis so that they include studies that have the data we need.

Q. What is your definition of primary endpoint? Because I think it may

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be different than mine.

A. Primary endpoint is the first and -- first priority end point result you're looking for in a study.

Q. Right.

And you think there's a single long-term randomized study out there with safety as the primary endpoint on the TVT-O product?

A. I don't think it's as a primary endpoint because it's pretty traditional to do efficacy and then safety. But a second endpoint doesn't diminish its value, statistical value.

Q. So the answer to my question as asked is "no."

Right?

MS. GERSTEL: Objection.

A. I would have to look through all the randomized studies to do that. I don't know that offhand.

Certainly most of them don't have it as the primary.

Q. What about is there a single

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randomized controlled trial with safety as the primary endpoint that specifically addresses the TVT-Abbrevo?

MS. GERSTEL: Objection.

A. I think your primary endpoint is a -- from the challenging the data on this as a primary endpoint is on the verge of incredible.

MR. DeGREEFF: Okay. I appreciate your thoughts on that. I really do. And I'll move to strike it. But I do want an answer to my question.

A. I would have to review each of them to see which ones have primary endpoints. I don't know off the top of my head if they have primary endpoints. So I don't know the answer to that question.

Q. And then same question for TVT-Exact.

Is there a single long-term randomized controlled trial with safety as the primary endpoint specifically addressing the TVT-Exact?

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A. That one I think I could tell you is no.

Q. Is there a single long-term randomized controlled study with safety as the primary endpoint that looks at the TVT?

MS. GERSTEL: Objection.

A. I'd have to look at the -- each randomized study. I can't answer that off the top of my head.

Q. There's not one you could think of?

A. Not off the top of my head.

Q. Ethicon has never done a study with the primary endpoint was to determine where or not laser-cut mesh is stiffer or safer than mechanical-cut mesh.

Right?

MS. GERSTEL: Objection.

A. I seem to recall there being some internal study of the laser-cut mesh. I can't recall all the details on it, but I think they did study the properties. If I recall, and again it's off the top of my

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head, I would have to find the document. I think it was determined that they felt it would not be a significant difference.

Q. Are you talking about testing or a study?

MS. GERSTEL: Objection.

A. Mechanical testing.

Q. I'm talking about a study.

Ethicon's never done a study where the primary endpoint is to determine whether or not laser-cut mesh is stiffer and less safe than mechanical-cut mesh.

Correct?

MS. GERSTEL: Objection.

A. A study in humans?

What type of study.

Q. Any kind of study.

A. Well, a lab is a study.

Q. Well, lab's a benchtop, right?

A. A study is when you investigate to find answers. It doesn't matter what location it's in, whether it's a lab or in a human. It can be a study.

Q. I think you and I define a study

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different.

You're talking about benchtop testing.

Right?

A. I'm talking about comparing properties. You compare one thing against another is the definition of a study.

Q. So anything that's ever done at Ethicon is a study, even if they're just doing it on a bench?

MS. GERSTEL: Objection.

A. Well, if we're just chatting about the study, it's not a study.

If they have two products and they're comparing how it behaves in different circumstances, that's a study.

Q. So, I guess can you answer my question or not?

And my question is Ethicon has never done a study where the primary endpoint is to determine whether or not laser-cut mesh is stiffer and less safe than mechanical-cut mesh?

MS. GERSTEL: Objection.

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BY MR. DeGREEFF:
Q. True?
MS. GERSTEL: Asked and answered.
A. If I'm recalling correctly, and I cannot put my reputation on it, I think the bench work study that they did looked at stiffness, but they couldn't, by that study, evaluate safety.
Q. We talked earlier about the Ethicon employees' e-mails about concerns about the outcomes related to stiffness of the mesh.
Right?
MS. GERSTEL: Objection.
A. We had that discussion, I do recall.
MR. DeGREEFF: I'm good. We can be done.
MS. GERSTEL: I have like five minutes.
Do you want to take a break, or should I just start?
MR. DeGREEFF: Go for it.

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MS. GERSTEL: I know we're all running on fumes.
EXAMINATION BY
MS. GERSTEL:
Q. Dr. Lind, you were asked some questions about the Advantage Fit Boston Scientific sling that you had a role in developing.
Is that correct?
A. Yes.
Q. Is it your opinion, despite that role in developing the Advantage Fit sling, that retropubic TVT is the gold standard?
MR. DeGREEFF: I'm going to object to form.
BY MS. GERSTEL:
Q. For surgical treatment of stress urinary incontinence in women?
A. Yes.
Q. Did the vast majority of your patients have excellent results with retropubic TVT?
MR. DeGREEFF: Object to form.

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A. Yes.
Q. And, doctor, you were asked some questions regarding Abbrevo being a shorter sling than TVT-O and TVT-Exact.
Do you recall that?
A. Yes.
Q. Is it correct that even though Abbrevo is not as long as a TVT-Exact or a TVT-O or a retropubic TVT that it is not a mini sling?
MR. DeGREEFF: Object to form.
A. I agree with that.
MR. DeGREEFF: You want to just give me an ongoing objection to leading?
MS. GERSTEL: Yes. Although I disagree that was leading.
MR. DeGREEFF: Well, you can't testify for him.
MS. GERSTEL: I'm not testifying for him.
MR. DeGREEFF: That's what you're doing right now.
MS. GERSTEL: I am not

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testifying for him. I asked him --
MR. DeGREEFF: I'll just keep objecting. That's fine.
BY MS. GERSTEL:
Q. Doctor, you were asked some questions regarding your own experience and results treating patients with TVT-O, TVT-Exact, and TVT-Abbrevo.
Is that correct?
A. Yes.
Q. Is your own experience with TVT-O, TVT-Abbrevo, and TVT-Exact consistent with what you have opined on as to the safety and efficacy of those products as based on the highest levels of medical literature?
MR. DeGREEFF: Object to form.
A. Yes.
Q. Doctor, you were asked some questions about what you have and have not reviewed --
MS. GERSTEL: Strike that.
Q. Doctor, you were asked some questions regarding your supplemental

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materials list.
Correct?
A. Yes.
Q. And you were asked some questions regarding which of the documents on that list you had or had not reviewed.
Correct?
A. Yes.
Q. Doctor, is it true that you read many, many medical articles and company documents and depositions and other such materials since you began your expert work with Ethicon?
MR. DeGREEFF: Object to form.
A. Yes.
Q. As you sit here today, is it true that you may or may not recall specific documents that you have reviewed that are listed on your materials list?
MR. DeGREEFF: Object to form.
A. That's true.
Q. And is that particularly true if you weren't shown the document when asked if you had or had not reviewed them?

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MR. DeGREEFF: Object to form.
A. Yes.
Q. I think that this was adequately covered by plaintiff's counsel's questioning.
But, doctor, were you asked some questions regarding whether you had --
MS. GERSTEL: Well, strike that.
Q. Doctor, earlier in this deposition you testified regarding closer analysis that you have done recently of the Schimpf, Teo, and Okulu articles.
Is that correct?
A. Yes.
Q. After that closer analysis of those articles, did your opinions as expressed in your report that's been marked as Exhibit 8, did your opinions change as a result of that closer analysis of those articles?
A. It didn't. It became strengthened with regards to the safety profile of the TVT-O.
MS. GERSTEL: That's all I have.

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MR. DeGREEFF: I just have two questions.
FURTHER EXAMINATION BY MR. DeGREEFF:
Q. Which device did you agree with counsel was the gold standard device?
A. I would say the retropubic TVT as well as the TVT-O.
Q. Okay.
Why are you not using the gold standard device?
MS. GERSTEL: Objection.
A. I do use the TVT-Exact, which I consider to be the extremely similar device with a modification that I like, which is a narrower shaft.
Q. You use it in one out of ten of your patients?
A. Right.
Q. Why would you not use the gold standard device in all of your patients?
MS. GERSTEL: Objection.
A. Because there was a -- there was a decision at one point to bring on

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Caldera for financial reasons. At that point, we were asked to convert over to that and see if it met our needs. It met my needs, and I like the flexibility, and I started using it for good fraction of my cases.
Q. Are you breaching the standard of care by not using the gold standard device?
MS. GERSTEL: Objection.
A. I'm using an FDA-approved device that I feel is excellent for its intended purposes, and it's been performing well for several years.
Q. Yes or no, you are not using what you just testified is the gold standard device.
Correct?
MS. GERSTEL: Objection.
A. I'm using the TVT-Exact in one-tenth of my cases, yes.
Q. In 90 percent of your cases, you are not using the device you have just testified is the gold standard device.

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Right?
MS. GERSTEL: Objection.
A. Correct.
Q. You were asked by your counsel if --
MR. DeGREEFF: Strike that. It doesn't matter.
All right. I'm done.
MS. GERSTEL: I just have one follow-up.
FURTHER EXAMINATION BY MS. GERSTEL:
Q. Doctor, this isn't a document that we have marked as an exhibit in this deposition, but are you familiar with the AUGS SUFU position statement on midurethral slings?
THE WITNESS: Actually, I need it -- I think I answered incorrectly on your last question.
MR. DeGREEFF: Well, we've got a different question pending now. So if your counsel wants to clear something up with you, she can ask you a

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question.
THE WITNESS: It has to do with the gold standard.
MS. GERSTEL: Go ahead.
MR. DeGREEFF: No, she can ask you a question if she wants to ask you something about it.
BY MS. GERSTEL:
Q. Doctor, what were you going to say?
MR. DeGREEFF: I'm going to object to the form. That's open-ended and allows for a narrative response.
A. Well, the TVT by Ethicon has the preponderance of the data. The meta-analyses that go over all the slings and all the data for slings certifies polyester synthetic midurethral slings as the gold standard of care. The meta-analysis do not specify Gynecare TVT as the standard of care.
So, Ford and Cochrane specify that tapes that pass in the obturator pathway and in the retropubic pathway, and

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then they give their -- they give their affirmation and every authoritative agency that's approving and ratifying midurethral slings as the standard of care ratifies midurethral slings.
So, it is -- while would certainly agree that the largest amount of data on midurethral slings comes from Ethicon, the number of time and decades and years and studies that have proven that the results are similar make it a midurethral sling and not necessarily a Gynecare TVT midurethral sling which is the standard of care.
So, in that regard, I continue to use the standard of care.
MR. DeGREEFF: Okay. I'm going to ask a follow-up question. I'll let your counsel finish.
MS. GERSTEL: Okay.
BY MS. GERSTEL:
Q. Doctor, I think you anticipated what my question was going to be.
First, doctor, I believe that

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you just misspoke now when you said "polyester."
Did you mean polypropylene?
A. Yes.
Q. And, doctor, I'll just re-ask that question.
Are you familiar with the AUGS SUFU position statement on mesh midurethral slings?
A. Yes.
Q. And does that position statement refer to polypropylene type 1 macroporous mesh midurethral slings regardless of route, transvaginally or retropubic, as the gold standard in surgical treatment for stress urinary incontinence in women?
A. Yes, it does.
Q. And do you agree with that opinion?
A. I do.
MS. GERSTEL: That's all I have.

FURTHER EXAMINATION BY
MR. DeGREEFF:

Q. Doctor, you are now withdrawing your earlier statement that the TVT products are the gold standard.

Correct?

MS. GERSTEL: Objection.

A. I would say based on the meta-analysis, yes.

Q. What your testimony is is that you believe midurethral slings to be the gold standard.

Right?

A. Yes.

MR. DeGREEFF: No further questions.

(Deposition adjourned at approximately 7:57 p.m.)

A C K N O W L E D G M E N T

STATE OF)
:ss
COUNTY OF)

I, LAWRENCE LIND, M.D., hereby certify that I have read the transcript of my testimony taken under oath in my deposition of August 8, 2019; that the transcript is a true and complete record of my testimony, and that the answers on the record as given by me are true and correct.

_____
LAWRENCE LIND, M.D.

Signed and subscribed to before me this _____ day of _____, 2019.

_____
Notary Public, State of

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C E R T I F I C A T E

STATE OF NEW YORK
COUNTY OF NEW YORK

I, Marie Foley, RMR, CRR, a Certified Realtime Reporter and Notary Public within and for the State of New York, do hereby certify:

THAT LAWRENCE LIND, M.D., the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by the witness.

I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 16th day of August, 2019.

_____
MARIE FOLEY, RMR, CRR

LAWYER'S NOTES

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